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Address.

THE RELATION OF NERVOUS AND MENTAL DISEASES TO GENERAL MEDICINE.

ADDRESS OF CHAIRMAN, DELIVERED BEFORE THE SECTION OF NERVOUS AND MENTAL DISEASES, AT THE FIFTY-SECOND ANNUAL MEETING OF THE A. M. A., AT ST. PAUL, MINN., JUNE 4-7, 1901.

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I will crave your indulgence, and take the liberty to depart from the regular order, as defined in the By-Laws of the Association, to the extent of omitting the usual summary of progress during the past year in the realm of neurology and psychiatry, as represented in the literature of our special work, and confine myself to the discussion of some of the tendencies of modern methods of investigation, and their interpretation, with relation to nervous disease in general. I have been particularly impressed by the increasing tendency to discuss the differentiation of the morbid histology of the nervous system, as if that included all there was to the pathology of nervous disease; to consider that general medical knowledge is of little value in the study of its etiology, and of no importance in establishing its therapeutics.

This is the age of mechanics; and the same inspiration which has led men from the pursuit of the philosopher's stone, and the invocation of the supernatural, to the patient observation and application of force in all of its forms to the material advancement and convenience of mankind, has affected science in general, and during the past twenty-five years medicine in particular. Hence, we now approach the study of human organism with the same methods and by similar means to those used in determining the properties of matter and the combination of force as manifested in inanimate nature. These methods are all the more alluring because they call for mechanical ingenuity more than mental effort, and the explanations they suggest of the manifestations of disease and their origin seem so rational and complete. Besides, these methods represent a natural reaction from the superstition and metaphysical speculation which persisted in medicine, and especially in psychiatry, even to the middle of the last century. I believe, however, that this reaction is going too far; that the human organism is something more than a mechanism; also that the morbid histological changes developed experimentally in animals, or found after death in human beings, are not necessarily the cause of the disease conditions they apparently create, any more than their presence in one organ of the body is proof that the disease is confined to that part of the organism. In other words, there can not be special change without general disease; and in the study and treatment of the special condition, the general involvement and its extent is the most important.

It has been asserted that in scientific medicine there is no place for the polemic, that hypotheses are dangerous, and that argument, other than that involved in the comparison of experiments, their vertification, and the construction of formulæ, is useless. I believe this assumption to be wrong; for, out of it has grown the modern tendency to reduce everything in medicine to mechanical terms, to lose sight of the relativity of all of the activities involved in life, and to develop what, for want of a better name, I will call the organ physiologist and pathologist, and as a natural result the medical specialist, who sees in the symptoms complained of by his patient only the manifestations of disease in the organ or system in which he is particularly interested. This tendency has become so conspicuously a characteristic of medical thought and method, that recently one of our prominent medical journals, in commenting editorially in approval of the dictum of a great German pathologist concerning the value of brevity in scientific communications, deprecated the publishing of the details of the clinical history or post-mortem findings in any given case, if they were not directly connected with the organ apparently involved, losing sight of the fact that there enters into the conclusions reached concerning any given case, not only the personal equation of the observer but also the influence of his special training upon his interpretation of the facts observed, and leaving out of consideration altogether the obvious inference that another observer differently situated might interpret the facts differently if all the data were presented to him. Neurology has become a series of demonstrations of the normal and morbid histology of the general nervous system, and the neurologist is endeavoring to apply this same method to the study of psychiatry; while the psychiatrist still discusses insanity in the terminology of metaphysics. The significance of this tendency is well expressed in the following quotation from Herbert Spencer:[1] "If insistence on them tends to unsettle established systems of belief, self-evident truths are by most people silently passed over; or else there is a tacit refusal to draw from them the most obvious inferences. Of self-evident truths so dealt with, the one which most concerns us is that the creature must live before it can act." I would paraphrase this statement thus: Those activities upon which the functioning of the nervous system depends are more important than the resulting activities that the nervous system directs. Because of methods of study and the still too prevalent metaphysical conception of the relation of the central nervous system to the activities of the rest of the organism, the neurologist has ignored the relation of his special work to general medicine, his studies have been confined largely to the motor apparatus of the nervous system, losing sight of the fact that the nervous system, while it directs all of the activities of the rest of the organism, supplies nothing toward its own nutrition and is not concerned in the elimination of the waste

materials of its own activity. Out of the failure to recognize the obvious inference from this fact in physiology has grown the therapeutic nihilism and sterility, referred to by the chairman of the Section in his address at Atlantic City last year.

In order to formulate my argument as to what constitutes what I believe to be the true relationship between general medicine and mental and nervous disease. I will posit certain data drawn from current sources of knowledge concerning the facts of development and physiology, as to the relation of the nervous system to the rest of the organism.

There are two assumptions we may safely make concerning the human organism, based upon what has been demonstrated as to the processes of its functional activity and is known of its cytology: 1, that the primary functions are those of vegetation, and that all others are related and in sequence to some form of activity involved in the process of nutrition; 2, that the nervous system is the last as well as most complex in the order of development. Also, the complexity of the nervous system has increased in a direct ratio with the demands upon the general organism, resulting from changes in its environment. It may further be assumed from our knowledge of biologic chemistry that the functional cell wherever found has a limited potentiality; also a normal plane of response to the incident forces constituted in its environment. This plane of response naturally will vary with the individual, and other things being equal, will depend for its level of development upon the combined capacities of the parents at the time of conception, the competence of the mother during pregnancy, and the suitableness of the individual environment up to the period of second dentition.*

It follows as a corollary of this statement, that if for any reason the potentiality of the functional cell is abnormally limited, or on account of untoward or disastrous conditions in the environment of the organism is manifested excessively, the limit of capacity in the area or organ will be prematurely reached and a degenerative process begin. That this is true the fact of arrested and defective development and instability in the nervous system, as well as the different tendencies toward degenerative processes in the vital organs abundantly prove. Further, those degenerative processes which are supposed to be confined to the spinal nervous system, have for their antecedents, conditions which interfere with general nutrition and elimination, for a long time before the symptoms of involvement of the structure of the spinal cord become apparent. It is unfortunate that the morbid changes in the histology of the nervous system should be obscured by the results of the degenerative process which accompanies chronic disease, so that we are unable to say that the changes found are not the result rather than the cause of the disease present during life, since we always find that these changes have for their chief characteristic, destruction of the functional cell and its more or less complete replacement by the structural tissue. This want of correspondence between the symptoms manifested and the amount of degenerative change in the nervous system is well shown in the only two acute conditions which give an opportunity to study the changes apparently causing the symptoms, unaccompanied by other changes which are consecutive. I refer to Landry's paralysis and acute delirium. In both of these disease conditions, while there is nothing distinctive in the morbid histology, there is abundant evidence of antecedent involvement of the vegetative organs, with more or less complete abeyance of both their nutritional and eliminatory functions. Even in those processes where the morbid histological changes are believed to be not only distinctive but characteristic, we have no evidence that the circulation is not first involved. This presumes the presence in the blood stream of some toxic substance acting as a persistent irritant, while the presence of this substance in the organism involves failure or incapacity in the vegetative organs, both as regards resistance to the entrance of toxic material and failure in its elimination.

It is not conceivable to me that the relations of the spinal nervous system to the rest of the organism, should be any different in kind than those of the cerebrum. The spinal nervous system represents the simplest and most direct relationship between the different parts of the organism, and we have it in common with those forms of animal life in which the functioning of the nervous system is confined to the direction of those activities which have for their object the acquisition of food and the avoidance of sources of danger which are obvious. Indeed, this is largely the limit of functional activity of the spinal nervous system in even the highest developed organism. In those forms of animal life having only a spinal nervous system, the vegetative functions remain inherent in the cell or group of cells comprising the organ—witness what we know of the inherent capacity of the heart and the so-called vital secretions of the different vegetative organs—but as the nervous system continues to evolve in response to the growing complexity of the general organism, resulting from changes in environment; there is a practically separate system developed for the control of the vegetative functions, and lastly, as the channels for the transmission of nutrient material, which at first carry all of the products of metabolism indifferently, are separated into an afferent and efferent system, there is evolved the ganglionic nervous mechanism for their control. All of these systems are in intimate association but the connection between the vegetative organs and circulatory apparatus, though the ganglionic is most close, and these with the cerebrum more intimate than with the spinal; which still has for its principal form of activity the transmission of common sensation, the locomotion of the general organism, and only indirectly the motor activity of the mechanism of the vegetative organs.

Any man who has worked much among the insane has abundant evidence of how all of those degenerative processes which are supposed to be the result of disease of the spinal cord and bulb can be mimicked during the course of progressive brain degeneration, and we know how promptly symptoms of involvement of the nervous system follow destructive or degenerative disease of the vital organs. While the pathologist finds in studying post-mortem the histological changes in the spinal cord which, from the standpoint of morbid anatomy, seem to him to be causative; he has only to examine the evidence furnished by the study of development and the causes which operate to arrest its processes or make them

* While I do not believe that we have any evidence of increase in the functional potentiality of the nerve cell after this period, there are undoubtedly marked increases both in number and special forms of activity, before and after puberty; and just as different areas in the nervous system because functionally active at different periods in the development of the embryo, so the level of the plane of response in the individual cell, functional group or area, may be raised at the different epochs in the order of development, without any increase in its potentiality, as shown in the limitation of the period of sexual activity as well as by the excessive activity of all metabolic processes during the period of adolescence, and the reduction in the plane of activity of those parts of the organism involved in the processes of nutrition, after the climacteric period, in both sexes.

aberrant, to realize that it is still at least an open question as to whether the disintegration he finds is not the result of the breaking down of an unstable structure, rather than the cause of the symptoms manifested. And that this break-down is in its turn dependent upon impaired nutrition and imperfect elimination following disease in the vegetative organs, not primarily specific affection of the nerve cell. Even in syringomyelia, if we consider the mode of development of the spinal cord, the weight of evidence from the natural history of the disease and the post-mortem findings, is in the direction of the process being one of atrophic degeneration, taking place in a tissue primarily defective and of limited potentiality.

Impaired nutrition involves either failure of supply, overuse, or imperfect elimination, and these in their turn affection of the blood vessels, or change in the character of the blood stream itself, either through impoverishment or the presence of some constituent which is toxic; and it is the persistence of these blood changes which give rise to the changes in the blood vessels. These changes involve in their turn the pre-existence of failure in one or more of the processes of metabolism or incapacity of the eliminatory organs. Therefore, while the symptoms manifested may have their origin in a destructive or degenerative process in some part of the nervous system, the real disease, upon the cure of which the ultimate recovery of the patient depends, has its existence in the vegetative organs, either in the ensemble of their functions or as affecting conspicuously some one of them. I believe we may safely say that all disease processes begin as intoxications, and this is so even with chronic degenerative processes in the nervous system. During ten years of careful observation of the phenomena connected with the development and manifestations of insanity, in more than three thousand cases, I have never failed to find intoxication either the result of imperfect elimination or failure in the processes of digestion and assimilation. Failure in elimination is most common and involves most frequently the kidneys, next the bowels, then the lungs and skin. Failure in the digestive processes is generally in the direction of an abeyance of function and in cases of depression this is sometimes so extreme that the active constituents of the gastric juice are entirely absent for considerable periods.

We are all familiar with the influence of emotion and fatigue upon the nervous system, and have seen how tremor, spasm, convulsion and even paralysis follow shock, while again they are apparently the result of violent gastro-intestinal disturbance or renal inadequacy. It is here that the question arises as to the truth and significance of my thesis. We recognize the effect of overstimulation of an organ or part in checking katabolic change, interfering with oxidation and leading to auto-intoxication; but the failure in capacity is just as much the result of the suspension of anabolism as it is of the abeyance of katabolism. For, obviously, life involves the persistence of anabolism, so that even aberrant functioning involves the persistence of the nutritive processes. The over-activity of the cell or part may be so great or its potentiality so limited that suspension of the nutritive process is complete and almost immediate; or the exhaustion may be more gradual, so that the interference with katabolism results in retention of so much waste material that the cell no longer is reconstituted but disintegrates. While I freely admit that these statements of what is involved in the processes of metabolism are trite and even elementary, yet it is equally true that the most obvious inferences to be drawn from them in their application to the study of mental and nervous disease are either ignored, or, if recognized, not appreciated, because we overlook the fact that the morphologic changes found in the cell simply represent the exaggeration of the processes which, kept in balance, constitute normal metabolism, and that these changes may proceed to a very considerable extent without involving the permanent death of the cell, provided the limit of its potentiality is not reached. This is graphically shown in the morphologic changes which take place in the cortical cells of that part of the brain anterior to the precentral fissure in acute delirium, which are alike, except in degree, both in those cases where death comes early as the result of pulmonary edema, or later from bulbar paralysis, and this difference in degree, other things being equal, will be found to depend upon the amount of instability or defect in the individual which limits his potentiality and exaggerates the manifestations of nervous disturbance.

I trust I may be pardoned for referring here to some of my own work, but I will venture to do so because I believe I can best illustrate my contention by relating the experience which first called my attention to the importance of appreciating the intimate relation between general somatic disturbance and mental and nervous disease.

Some years ago I gave considerable study to the mode of death among the chronic patients in St. Peter's Hospital, and found that no matter what the apparent somatic disease, all of them presented marked symptoms of uremic poisoning, and the condition of the kidneys was confirmed by uranalysis. I noted further that death came in one of four ways: 1, suddenly from apparent cerebral hemorrhage; 2, apparent collapse with syncope; 3, more slowly with dilatation of the right heart, pulmonary edema, vasomotor paresis and death from asphyxia; 4, apparent asthenic bulbar palsy; sometimes rapidly fatal; again accompanied by a mono- or di-plegia, a hemi- or para-plegia of varying degree of completeness, death resulting from progressive asthenia. The merging of these different modes of death into each other was also noted from time to time, especially among the victims of chronic degenerative disease of the lungs. The necropsy failed to reveal any evidence of gross lesion or degenerative change to account for the symptoms and conditions present during life; but certain changes were found which have been described by me elsewhere.[2] This experience led to the systematic study of the urine in our chronic cases to determine if possible how far the nervous manifestations of uremia might be anticipated. We found that profound changes might be present in the structure of the kidney without the presence of albumin or casts, and in the absence of the ordinary clinical signs of nephritis. Also, that in proportion, as the nervous symptoms of uremia were present, were the ordinary somatic manifestations absent. Furthermore, we found that uremic poisoning, fatal in result, might be present as the result of auto-intoxication from imperfect metabolism, acting through the vasomotor apparatus and bringing about the abeyance of the function of the kidney as the result of vasomotor spasm producing ischemia, and in the absence of any marked degenerative change in the kidney itself. That is, the function of the kidney as a filter was not interfered with, but the secretion and excretion of the solid constituents of the urine was diminished and the chlorids

often entirely absent, while, for obvious reasons, urea would not be diminished in amount. In cases of parenchymatous nephritis and the diffuse form where the medullary substance of the kidney is most involved, the diminution of the excretion of urea was the rule and albumin and casts more common.

This experience led us to study more carefully similar conditions among the recent cases, and we found to our surprise that practically all cases admitted to the hospital gave evidence of some degree of renal inadequacy. In the cases of so-called delirious mania and in delirium associated with other forms of insanity the evidence of imperfect elimination was marked; and furthermore our success in relieving these conditions was always in proportion and in sequence to the re-establishment of the function of the kidneys. In those cases which proved fatal and had been accompanied by high temperature with vasomotor paresis before death, the change in the kidneys was found to be parenchymatous; while in those without elevation of temperature but exhibiting progressive asthenia the change in the kidney was interstitial. By following the same method in the study of the other vital functions, the intimate association between irritability, exacerbations of excitement, disturbance of the special senses, recrudescence of delusion, and impairment of digestion with constipation was determined.

Bearing in mind that in a hospital for the insane, on account of the environment of the patient, the conditions which modify and complicate the progress of degenerative processes in general practice are absent, that the life of the individual is ordered, his diet and occupation controlled, and that in the demented vegetation dominates and often comprises the activities of the organism; it will be readily understood why we see so conspicuously manifested the changes in the vegetative organs, and the influence of interference with or abeyance of their functions in the determination and progress of degenerative processes in the nervous system.

If then these conditions exist among the insane in hospitals, they must necessarily have existed in the same individuals before they came to the hospital, and there is *a priori* reason to believe that they also exist among the sane and especially among those suffering from degenerative processes in the nervous system. Personally my observations as a consultant confirm, in this connection, my experience in hospital work, and lead me to believe that in the appreciation of general nervous disease, the prognosis, and especially in our therapeutic efforts, we are more concerned with the functioning of the vegetative organs and the general processes of metabolism than with the morbid anatomy and histology of the nervous structure; or, to express the conclusion tersely, we are more concerned with function than with form; for the morphologic change seldom determines definitely what the nature of the disturbance of nutrition has been even if it does indicate the result.

I do not wish to be understood as failing to appreciate the value and significance of modern methods of research nor to oppose my limited understanding of the results attained to the general opinion. But I feel justified in suggesting for your consideration the fact that the study of the pathology of nervous and mental disease has not advanced proportionately with the development of methods for the recognition of its morbid histology. And I believe that the apparent futility of therapeutic effort in disease of the general nervous system, has resulted from the giving of undue significance to the morphology of the changes found after death in man, or produced experimentally in animals; and too little study and care to the general processes of metabolism as represented in the functioning of the vegetative organs.

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Original Articles.

ORAL MANIFESTATIONS AND ALLIED STATES.

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(Concluded from p. 1766.)

The following autopsy was made on an old man, in whose case the pathologic diagnosis was as follows: Senile marasmus (senile emphysema, senile sclerosis of the aorta, atrophy of the parenchymatous organs), scurvy (hemorrhagic gingivitis); chronic aortic and mitral endocarditis; fibrous myocarditis; chronic nephritis; caseo-calcareous areas in the right apex, spleen and left adrenal; double hydrothorax; bronchitis; fibroma of the stomach; amputation of the left lower extremity at the lower third of the thigh. The findings unrelated to the scope of the present investigations are omitted. The gums were found swollen, and here and there infiltrated with blood. There was purulent matter about the roots of the teeth, many of which were loosened and some of which could be removed with the fingers. The roots of the loosened teeth were covered with a granular, grayish material.

Only the lower frontal teeth and corresponding part of the jaw could be examined. The epithelial covering of the gums appeared to be quite intact. In some places it was a little thickened, and its lower layers infiltrated with new cells. The sub-epithelial tissue was much thickened, presenting the general structure of an inflammatory granulation tissue of some standing. Areas occurred in which there were many new cells and but little stroma. In other foci the tissue was more fibrous, the new cells running in bands. Here and there occurred free and intracellular granular, yellow pigment. Typical hyaline bodies of various sizes, and staining a precise bluish-violet with Gram's method were found in rather small numbers. In some places small sub-epithelial abscesses were met with, which (in the instance of a district including a lower incisor) were really subperiosteal. The contents consisted of nuclear detritus and bacteria (mostly cocci) which have accumulated, especially upon and in the walls of the minute cavities extending from such an abscess. There seems to be a complete occlusion of the vessels (capillaries) with typical bacteria masses, staining a peculiar bluish-violet color with hematoxylin, and blue with Gram's method, so that the vessels presented the appearance of being very successfully filled by an infection mass. The small dilatations, the branches and the larger vessels (judging from structure these seemed to be veins) were sometimes brought out very nicely. The intravascular growth of bacteria extended into the bone below as well as, and more especially into, the peridental membrane. These abscesses (suppurative periostitis) occur almost exclusively upon the inner surface of the alveolar process, being confined (as far as there was occasion to

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observe) to the external aspect of the process. There was always a thin, sound layer of bone separating the abscess from the peridental membrane. Very generally the spaces in the adjacent bone were filled with a cellular fibrous tissue in which occurred islands of osteoid tissue. The bone trabeculæ were generally covered by a thin layer of osteoid tissue, which (from the greater number of cells it contains, as compared with the other bones) must be newly formed. Rows of osteoblasts were found often upon the trabeculæ. Few Howship's lacunæ were found, and these were filled with small cells. There were no osteoblasts in the areas about the abscesses. The bone outside of the alveolar process is quite unchanged.

The "bacterial thrombosis" not unusually extended into the peridental membrane, which then refused to stain as clearly as normal. The upper part of the peri-

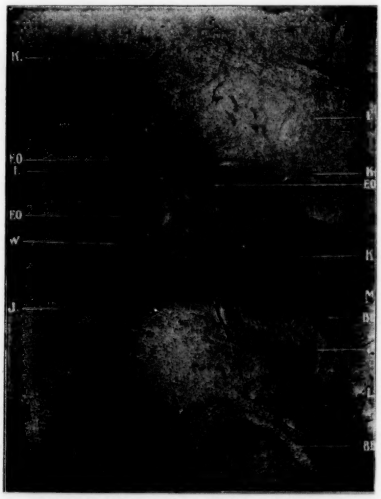
X 40. 35 M. M. Zeiss. Micro-photograph reduced four-sevenths.

Fig. 17.—Longitudinal Section of Tooth. Alveolar Process and Gingival Border, Showing Active Inflammation in Scurvy in Man.—B, Sentine. C, Cementum. E, Epithelial tissue. G, Submucous membrane. H, Periosteum. J, Alveolar process. L, Haversian canals. M, Fibrous tissue. V, Violent inflammation. AA, Point of union of epithelial tissue and peridental membrane. RR, space pocket from want of union of the epithelial fold.

dental membrane was usually the seat of cell proliferation and of formation of fibrous, due to the direct extension of the similar process in the sub-epitheial connective tissue of the gingivus. There were no indications that the process began below, at the apex of the tooth, for example, and extended upward. In the peridental membrane, and often connected with the cementum of every tooth examined, were very many so-called calco-spherites; calcified, concentrically lamellated, round or oval bodies, not unlike the "corpora amylacea." In many instances, it seemed as if the body had formed in the cement or at its margin—the cement presenting here a nodular condition.

Fig. 17 illustrates a section through the tissues of the jaw and cuspid tooth. The epithelium is not so dense and thick as in a similar section from the dog. Inflammation extends along the capillary layer of the submucous membrane (G) and involves the deeper structures. The mucous membrane layer has doubled upon itself, forming a pocket (RR). Violent inflammation is evident at V. This is of unusual interest, since it demonstrates that inflammatory products may be carried by the blood-vessels anywhere throughout the alveolar process, and may result in abscesses. The inflammation extends throughout the periosteum (H), the fibers of which extend from the root of the tooth over the border of the alveolar process (J). There the coarse fibers of the periosteum contrast decidedly with the finer fibers of the sub-epithelium. Absorption and contraction of the alveolar process (fully one-half the length of the root of the tooth) has taken place, as well as lateral absorption. The inflammatory process extends through the Haversian canals (L).

Fig. 18 illustrates a section of the peridental mem-



X 75. A. A. obj. Zeiss. Micro-photograph, reduced four-sevenths.

Fig. 18.—Cross-section of Inflamed Peridental Membrane. Scurvy in Man.—I, Peridental membrane. J, Alveolar process. K, Capillaries. L, Haversian canals. BB, Blood vessels of Von Ebner, preceding perforating canals. EO, Endarteritis obliterans. W, Epithelial débris.

brane (I) and alveolar process (J) with inflammation extending throughout. Capillaries (K) are also noticeable in large quantities nearer the alveolar process than the root of the tooth. Epithelial débris are evident at W. Endarteritis obliterans (EO) may be seen in different portions of the field. Inflammation has extended into the Haversian canals (L) but absorption has not occurred to any great extent. The blood-vessels of Von Ebner (BB) are quite well shown.

Fig. 19 is a section showing the cementum (C), the peridental membrane (I) and the alveolar process (J). Marked inflammation extends through the peridental membrane, thence through the Haversian canals (which are entirely obliterated). Absorption of the trabeculæ (halisteresis) has resulted to the extent that what remains of the alveolar process (J) are islands of bone held in place by fibrous tissue. Blood-vessels of Von Ebner with perforating canals are seen at P.

Fig. 20 illustrates a large abscess (Y) from another location. This is also situated within the alveolar wall, showing that the inflammatory products extend through the blood-vessels. Marked inflammation is seen upon the side next to the peridental membrane (I^1), while rapid absorption—halisteresis (Q) and perforating canal (P)—is proceeding at the borders of the abscess and nearest the alveolar process.

A 48-year-old merchant was dyspeptic, debilitated and asthmatic, and for the treatment of the conditions he had been under calomel and tonics for a little less than two weeks. When he came under observation, the mucous membrane and gums were then much inflamed. There was marked sialorrhea. The teeth were loose. The gums were swollen. Pus oozed from the gums. The breath had a decided metallic odor. At my suggestion, his medical attendant stopped the calomel. He

X 75. A. A. obj. Zeiss. Micro-photograph, reduced four-sevenths.
Fig. 19.—Cross-section of Tooth, Alveolar Process and Peridental Membrane, Showing Active Inflammation and Absorption of Bone. Scurvy in Man.—C, Cementum. I, Peridental membrane. J, Alveolar process. P, Perforating canal absorption. V, Violent inflammation.

was then ordered six pints of spring water daily. The gums were, on alternate days, saturated with iodin. In a few days the soreness and swelling were so reduced that the deposits could be removed. The patient was discharged cured in a short time, other than as to the right inferior second molar, which was so loose as to require removal. This tooth was placed immediately in 50 per cent. alcohol for twenty-four hours and then removed to absolute alcohol for twenty-four hours more. The membranes had receded about two-thirds the length of the root. Sections for microscopic purposes were made from the lower third of the root. Of these sections Fig. 21 shows a small fragment of inflamed peridental membrane. Fig. 22 exhibits violent round-cell inflammation, degeneration and liquefaction of tissue.

A 35-year-old diabetic painter came under observation for plumbic poisoning. His gums were swollen. There was decided sialorrhea. The teeth were loose. Pus flowed from the gums. He was placed on ozonate spring water and the gums were saturated with iodin on alternate days. Three loose teeth were removed and placed in alcohol. Sections from the upper third of the left superior second bicuspid gave results on microscopic examination similar to those already described as occurring in mercurial poisoning. Fig. 23 shows round cells of inflammation. Fig. 24 illustrates very marked degeneration of the peridental membrane. In the lower right-hand corner are seen the root of the tooth, dentine and cementum. The whole surface of the peridental membrane is in an advanced phase of inflammation. Just at the border of the root is evident an area of membrane softening. Just beyond, but joining, is noticeable breaking down of tissue. In the center are seen two areas of softened tissue more advanced in degeneration.

One occupation disease which has been ignored in

X 75. A. A. obj. Zeiss. Micro-photograph, reduced four-sevenths.
Fig. 20.—Cross-section of Peridental Membrane and Alveolar Process, Showing Active Inflammation and Another Large Abscess. Scurvy in Man.—J, Alveolar process. P, Perforating canal absorption. V, Violent inflammation. Y, Abscess. I^1, Inflamed peridental membrane. L^1, Inflammation extending through enlarged Haversian canals.

the etiology of interstitial gingivitis is "brass-workers' ague." In almost all brass-workers, a stain varying from a brown to a brownish-green is detectible on the necks of the teeth betwen the crowns and the gum insertion. This is most obvious in the upper jaw. After a while, as E. Hogben[4] has shown, the teeth become loosened and fall out. Before these changes in the gums appear nervous symptoms have developed from the brass poisoning.

Arsenic should be taken into acount in the etiology of interstitial gingivitis. This drug has a very decided tendency in certain subjects to cause, even in small doses, marked stomatitis and irritation of the mucous membranes throughout the body.

Tartar emetic and other preparations of antimony, producing iritation of the mucous membranes of the

4. Birmingham Medical Review, 1887.

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mouth, and elsewhere, may act as predisposing and exciting factors of interstitial gingivitis.[5]

Among the drugs which should be taken into account in the etiology of interstitial gingivitis is potassium bromid. This produces in certain individuals, or when given to excess, marked increase of the saliva with irritation of the mucous membranes of the mouth, followed

Figure 21.

later by dryness of the mouth and shrinking of the gums. The bromids have, as H. C. B. Alexander[6] has shown, a tendency to irritate all the mucous membranes of the body as well as the skin. Therefore, in dealing with cases of interstitial gingivitis in which the bromids are being taken, this factor should not be neglected. In these cases the symptoms due to the bromids are apt

Figure 22.

to be charged to the nervous state for which the bromids have been given. The irritation of the mucous membrane by the bromids may occur quite early among the untoward effects produced by them. In all probability the bromin rather than the alkali is the source of these untoward effects.

What is true of the bromids is also true to an even greater degree, as has elsewhere been shown of the iodids.

The poison in the blood, together with the diseased peripheral nerves, produce irritation and inflammation of the inner coat of the capillaries. If this irritation does not disappear soon after its inception, the inflam-

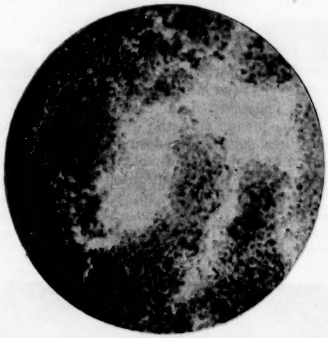

Figure 23.

mation tends to affect the other coats of the blood-vessels. Under certain conditions, endarteritis may, however, never involve the other coats of the vessels. When irritation of the inner coat of the capillaries takes place proliferation of the endothelium occurs. This inflammatory growth tends to obstruct the lumen of the vessel. The media may likewise become thickened by

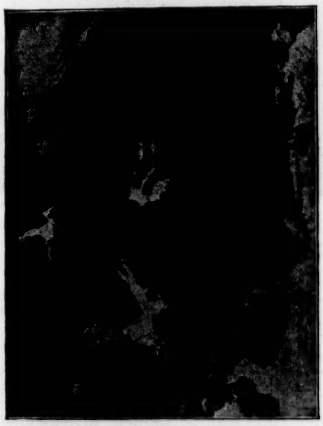

Figure 24.

an increased connective tissue. The capillaries become obstructed, and finally obliterated. This finally impedes the circulation. Fig. 25 shows such a condition in the scurvy case, elsewhere illustrated.

Irritation may be of less intensity but greater duration, as in case of syphilis, tuberculosis, scurvy, mercurialism, plumbism, etc., and the results are then slowly effected. Proliferation of sub-endothelial connective tissue gradually increases until it reaches its limit (endarteritis obliterans). This influence of the pro-

5. Lewin: Untoward Effects of Drugs.
6. Alienist and Neurologist, July, 1896.

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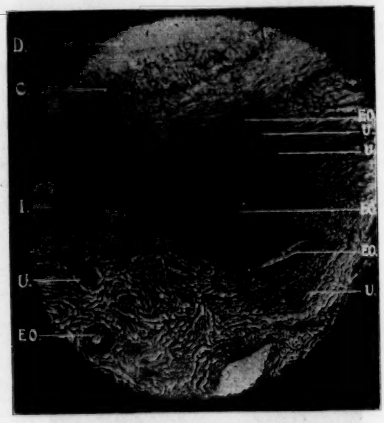
liferation is exerted in addition to that of the round-cell infiltration about the structure.

The recent studies of Hektoen[7] on meningeal tuberculosis demonstrate that tubercle bacilli may penetrate the unbroken endothelial layers of the vessel and stimulate marked proliferation of the sub-endothelial connective tissue. An internal irritant, such as may be produced in the course of any infectious disease or from suboxidation, probably acts upon the endothelium of the walls of the smaller blood-vessels in such a way as to permit the escape through the walls, first of serum, then of leucocytes, the latter infecting and surrounding the vessels. The effect of the chronic endarteritis is to check the blood supply to the gum tissue. Mercury, lead, and other poisons circulating through the blood are forced to remain, hence discoloration of tissue along the gum margin. Interstitial gingivitis, resulting in a slow disturbance of nutrition, produces overgrowth of connective tissue. In all cases of chronic interstitial gingivitis, as shown in the illustration, blood-vessels are thus involved.



X 150. D. D. obj. Zeiss.

Fig. 25.—Cross-section of Peridental Membrane, Showing Endarteritis Obliterans. Scurvy in Man.—C, Cementum. D, Dentine. I, Peridental membrane. U, Nerve tissue. EO, Endarteritis obliterans.

Among the predisposing influences which cause this disease are syphilis, tuberculosis, mercurialism, plumbism, brass poisoning, lithemia, nephritis, gout, rheumatism, alcoholism, nervous diseases, pregnancy and old age. Under certain conditions of the system any and all diseases which tend to lower the vitality, producing anemia, will assist in producing this disease. The direct cause may be resultant overstrain of the blood-vessels.

Owing to obliteration of the arterioles in the alveolar process, stasis of the blood must follow. The detritus from the alveolar process, therefore, must remain in the tissue and collect upon the roots of the teeth.

The reason disturbances of the system manifest themselves so readily upon the gums and alveolar process, is due to their unstable and transitory nature, hence the marked impression made by autointoxication and drug poisons.

7. American System of the Practice of Medicine, p. 119.

In conclusion, I would say that the etiology of this disease may be divided into local and constitutional causes. The local may be due to irritation about the gingival borders of the gums, such as tartar, crown and bridge work, etc. The constitutional causes are autointoxication and drug poisoning. These act by direct irritation through the peripheral nerves and the blood streams (as shown in the experiments by mercurialization of dogs) setting up the inflammation in the capillaries extending throughout the alveolar process and gum tissue. Endarteritis obliterans results, cutting off the blood supply. A new source of danger to be guarded against is the administration of drugs, more especially those of mercury.

The question has arisen whether there exists a specific bacterium which bears the same relation to the pyorrheic stage that the streptococcus does to streptococcus diphtheria. This question, raised by Galippe, must, in the light of careful research, be regarded as settled in the negative. No special bacterium has been found which complies with the laws of Koch. Dogs are liable to this disease. Galippe had but to infect their gums with his bacterium to demonstrate its specific pathogenic activity. He has not done this. As the researches (already cited) also failed to find a bacterium which could comply with this test required by the laws of Koch, it must be admitted that there is no bacteriologic evidence of a specific bacterium. Furthermore, the pathologic evidence demonstrates that bacteria play the very subordinate rôle in this disease that they do in ordinary wound infection.

Clinical Reports.

REPORT OF A CASE OF PUERPERAL ECLAMPSIA, WITH RECOVERY.*

JAMES E. DAVIS, M.D
DETROIT, MICH.

There is nothing unusual in this case. It is reported because each experience teaches us lessons which may be mutually profitable.

L. S., aged 20, moderately well nourished, and weighing 120 pounds, with previous health good, period of gestation complete and normal, was in labor about fourteen hours. Examination showed dilatation nearly complete, vertex presenting, pains strong; pulse 86, character good, excepting a slight high tension; action regular. After about fifteen minutes, during which time there were some four or five pains, descent had taken place almost to the perineum and the membranes had ruptured, when, without warning, a convulsion lasting about one minute occurred, manifesting about all the classic symptoms. The stertorous respiration, opisthotonus and depression of pulse were very marked. A semi-comatose condition ensued for about forty minutes, when a second convulsion lasting about thirty seconds occurred. This was followed by a condition of extreme irritability with threatening convulsive seizures for a little over two hours. During this time the pulse was an interesting study, the average rate being 160. Immediately after the first convulsion the character was decidedly thready and irregular, some beats showing high tension, and some being almost imperceptible. Improvement was gradual, and in three hours the rate was 96 and the character improved. A quiet and sound sleep ensued and lasted eight hours with but two waking periods aggregating forty minutes. The subsequent course of the case up to the present, which is eight days, has been uneventful, excepting that on Sunday, the fifth day, a slight convulsion occurred lasting but a few seconds, with succeeding slight stupor for two hours.

Treatment.—The patient was first seen by the writer eleven

* Read before the Detroit Medical Society, Jan. 30, 1901.

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days prior to confinement. There was nothing in the appearance of premonitory eclampsia symptoms, excepting a slight edema of the face, feet and legs. Examination of the urine gave the following: sp. gr., 1022; reaction, slightly acid; albumin 1 per cent.; urea about 2.5 per cent.; quantity passed in twenty-four hours, 45 ounces.

An exclusive milk diet was ordered, with a daily cathartic of Rochelle salts and ½ oz. of infusion of digitalis three times a day. Daily baths and plain water *ad libitum*.

Immediately after the onset of the first convulsion chloroform was administered during the period of spasm, followed by ½ dram of fluid extract of veratrum viride. Chloroform was next resumed and a forceps delivery performed quickly and easily. The child was normal and strong. The placenta was delivered without difficulty, in about ten minutes; hemorrhage following was normal. The bladder contained 2½ ounces of urine, which was drawn by the catheter soon after delivery. Analysis: sp. gr. 1022; reaction, acid; urea, 2.5 per cent.; albumin, 2 per cent.; a large number of granular and hyaline casts, some of which contained pus cells.

Strychnia sulphate—1/60 grain—was given hypodermatically at the end of the placental delivery, to support the heart; in about half an hour after this, morphia sulph., ½ gr. The second convulsion was controlled, as the first, by a few whiffs of chloroform. The pulse and nervous symptoms now became gradually quieter and 30 grains of chloral hydrate was given in 16 ounces of water, per rectum. Two hot-water bottles were kept under the lumbar regions. At 7:30 o'clock, 3½ hours after the first convulsion, perspiration was very free and the patient relaxed into a quiet sleep.

Subsequent treatment has been potassium citrate, 1 dram in 8 ounces of water every two hours, free catharsis daily, and free perspiration once daily, which was secured easily by the hot-water bottles.

During the first thirteen hours succeeding delivery, 10 ounces of urine were secreted, and since this time from 35 to 45 ounces daily. A milk diet has been rigidly enforced.

Repeated examinations of urine show persistent albuminuria, though much reduced in severity.

831 Fort Street, West.

CESAREAN SECTION THREE TIMES IN THE SAME PERSON IN SIX AND ONE-HALF YEARS.

J. W. COAKLEY, M.D.

MT. ETNA, IA.

August 3, 1893 I was called to see Mrs. P., aged 30 years, in her fourth pregnancy. She had had previously one abortion, and I had performed craniotomy in two preceding labors on account of a contraction of the pelvis. Its conjugate diameter was but two and a half inches. I decided not to destroy this, the fourth child, and the mother consented to an operation. I operated on the morning of August 4, assisted by Drs. Sweet and Bryant. Every antiseptic detail was carried out. I made an incision to the peritoneum, through the abdominal wall in the median line, from 4 inches above the umbilicus to within 2 inches of the pubes. The peritoneum was opened on a grooved director with scissors and the uterus lifted bodily outside the abdominal cavity and wrapped in hot antiseptic towels. The upper part of the wound was temporarily closed with silver sutures to retain the abdominal contents; a broad, flat sponge was wrung out in hot boric acid solution, and placed posterior to the uterus over the abdominal incision for further safety; a rubber ligature was passed around the neck of the uterus to prevent hemorrhage. The peritoneum being opened, an incision 4 inches long into the uterus and penetrating to the sac was then made, and the child was removed with membranes intact; no vessels of any size were severed. The rubber ligature was taken off, uterus washed out with hot antiseptic solution. The edges of the wound of the uterus were brought together with catgut, about half an inch apart, made with a curved needle, quarter of an inch from the edge of the incision through the muscular tissue of the uterus, but not including the mucous membrane. Sutures were tied firmly, but not so tight as to strangulate the enclosed tissue.

For the purpose of approximating still more the edges of the incision, a set of superficial stitches of silkworm gut were inserted between the other stitches about quarter the thickness of the uterine walls. Then uterine incision was dusted with iodoform. We concluded not to irrigate, because no blood or septic material was found within the abdomen. The peritoneum was united with continuous sutures of silkworm gut; the abdominal wall was next coaptated with interrupted sutures of silk, the whole wound being dressed with iodoform gauze and absorbent cotton. The next day her temperature was normal and but for slight vomiting from the effects of the anesthetic, the patient was quiet.

On the third day, she had a little fever for the first, owing to secretion of milk; the temperature of 100 lasted one day. On the fourth day temp. normal and she furnished milk for infant and was anxious for food to appease her own appetite. On the fifth day, bowels moved and temp. normal.

On same day dressings were changed, wound completely healed by first intention. On the tenth day, no untoward symptoms. On the 21st day patient walked through house, and felt as well as ever, excepting muscular debility.

I was again called to see this woman in labor at full term pregnancy on July 27, 1895. I was assisted in this operation by Drs. Sweet, Salts and Davis. This time the case was somewhat complicated by reason of the placenta being attached near and over the os uteri, as in case of placenta previa. I cut through the former cicatrix and found the wall of the uterus to be extremely thin.

The rubber ligature was tightened, the child turned, to save time, membranes were ruptured, child removed and turned over to Dr. Salts.

Placenta quickly removed with all adherent portions of decidua carefully separated, all subsequent details finished as related in first operation. The patient did not lose more than an ounce of blood at most; neither had I to ligate, nor to use torsion on any vessels. Her temperature rose one degree above normal on the third day at the appearance of the milk.

During a subsequent pregnancy in the same patient her husband came to me about the eighth month and informed me that his wife was pregnant and wished another operation. He thought his wife was in average health for her; I called on her in about ten days from that time to make some arrangement for the operation. This visit was in February, 1900, and I was surprised to find my patient in rather poor health, with urine quite heavily loaded with albumin; considerable headache and other symptoms belonging to this condition.

I put her on treatment to build up system and relieve kidney trouble. I was again called to see her in labor on March 2, 1900, and being about 20 miles out in the country, I was called by telephone in the afternoon. I did not arrive in time to operate, that day, so I gave morphia to control pains and postponed the operation until the next morning and had patient prepared, as in the two preceeding operations. Next morning, March 3, I gave patient morphia and atropin with strychnia.

At this operation I had as assistants Drs. Sweet, my son, a medical student, and Miss Belle Shaw as special nurse.

After the patient was under full anesthesia, I made an incision down to the peritoneum, through the abdominal wall. I found the peritoneum adhered to the uterus, also to the abdominal wall in places. I cut down at the side of the old cicatrix, which in my opinion, is the best way.

I broke up the adhesions and lifted the gravid uterus bodily outside of the abdomen, wrapped it in hot towels and made an incision 4 in. long in the uterus, after placing a gauze pad under and around the uterus to prevent any amniotic fluid from getting into the abdominal cavity. This time I did not use the rubber ligature and would not do so again, as it certainly will injure the tissues of the uterus, if placed around tight enough to control hemorrhage.

In 13 minutes from the time I commenced the operation, I had completed all, and was ready to tie the abdominal sutures. The wound was dressed in same manner as in preceding operations. There was but one-half ounce of chloroform used during this, the third operation. The mother was awake and making inquiry of nurse as to whether the babe was a girl or a boy in twenty minutes from time operation commenced.

The next day after operation temperature normal; some nausea from effects of chloroform. Third day: temperature normal. Fourth, 1.5 above normal. Fifth day: bowels moved, temperature normal, dressing changed, found incision hermetically sealed by first intention. We used intra-uterine douches, as before, for first four days only. There were no untoward symptoms after fifth day and patient made a rapid recovery.

Having sold their farm, they moved a distance of 3 miles on the 20th day, with no bad effects whatever. The oldest child, a bright little girl, is attending school and her teacher claims the honor of teaching one pupil that was never born.

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SATURDAY, JUNE 29, 1901.

THE LARGE amount of space occupied by the Index in this issue necessitates the entire omission of some of the departments, and a reduction in the amount of space devoted to others.

THE INDEX OF AMERICAN MEDICAL LITERATURE.

There is one part of the Index printed in this issue of THE JOURNAL to which we desire to call attention. It has been a feature of the last four volumes, and yet it has been lost to many of our readers, because its nature has not been known. The feature referred to is the Index to American Medical Literature, commencing on page 1878. This is, in truth, an "Index Medicus" of American Medical Literature, covering, as it does, practically all the original articles in all the reputable medical journals of this country and Canada, except those which appeared in THE JOURNAL. Under "Index of Authors" is given the name of every author who has published a paper in the journals during the six months, giving references which include the titles of papers and where published. The Index to the titles is crossed sufficiently to enable one to look up any subject.

This phase of our index takes a large amount of labor and we do not hesitate to call attention to it thus prominently, believing that this effort on our part needs only to be known to be appreciated. The Index of American Medical Literature will be issued separately, and bound, with the titles as these were printed in THE JOURNAL each week. It will make a ready reference to authors, titles and subjects comparatively easy. This will be supplied to members and subscribers at 10 cents, and to others at 25 cents.

SERUM DIAGNOSIS OF BLOOD FOR FORENSIC PURPOSES.

The determination of the nature of traces of blood for forensic purposes is a very difficult problem, which often can not be cleared up sufficiently to afford definite aid to the administration of law and justice. Soon after the discovery, by Bordet, of cytotoxins produced by injecting the blood of an animal into another animal of a different species, it was found that hemolytic serum also has a precipitating action. It has been shown by Nolf that the precipitation develops as the result of the injection of serum without admixture of red corpuscles. Like the hemolytic action, the precipitating property is also strictly specific, becoming evident only when the serum is mixed with the blood of the species that furnished the blood for injection. Deutsch[1] found that prepared serum has the same—both hemolytic and precipitating—action on dried as on fresh blood, and thus the idea developed that serum diagnosis might be made available for forensic purposes. The method of preparation of hemolytic and precipitating serum for human blood consequently becomes an important question. In general, Deutsch has found that three injections into the subcutaneous tissue of rabbits, of 10 c.c. of sedimented red corpuscles, repeated at intervals of seven days, gives a strong hemolytic serum, which, when diluted four times with an emulsion made with dried human blood, causes complete solution of the fragments and scales of red corpuscles at the same time as a granular precipitate forms. Such experiments are made best in capillary tubes or as hanging-drop preparations, which are placed in the incubator for some hours. It should be repeated that the serum prepared as stated above has no such action upon the red corpuscles of any other animal. Deutsch emphasizes the important point that hemolytic serum acts upon ordinary dried blood, but not upon blood corpuscles that have been "fixed" by alcohol, formalin, heat or any of the other methods of fixation.

Uhlenhuth, Wassermann and Schütze, and others also have pointed out the forensic importance of the precipitation which takes place when prepared serum is mixed with the serum of the animal species which furnished the injected blood; and this method may be found of service, especially when the blood trace or spot is so old and dry that intact or approximately intact corpuscles no longer are present at all. But in the case of more recent blood it would seem that use might well be made of the dissolving action as well as of the precipitating action of the prepared serum. We have here another example of the eminently practical application of observations which at first seemed eminently scientific and abstruse.

MEMBRANOUS ENTERITIS.

Some difference of opinion prevails as to whether the curious disorder attended with the discharge from the bowel of masses or shreds or bands or tubes of mucus is really a single affection or represents two distinct diseases, both etiologically and clinically. Some writers speak of mucous colic and of membranous enteritis, the former being looked upon as an intestinal neurosis, characterized by severe paroxysms of abdominal pain, associated with the discharge of membrane from the bowel and unattended with anatomic alteration; while membranous enteritis is attended with slight pain and exhibits the anatomic features of chronic catarrh of the intestine. In both the formation of membrane must be attributed to a secretory neurosis, in the one idiopathic—that is, without obvious cause—and in the other secondary to the intestinal condition. Some observers

1. Centralbl. f. Bakt., Abt. i, 1901, xxix, 661.

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contend for the existence also of a sensory neurosis.

An interesting group of cases illustrating the various phases of the disorder under consideration is reported by Dr. H. Westphalen,[1] from a study of which, in conjunction with the opinions of others, he dissents from the view that makes a separation of mucous colitis and membranous enteritis as distinct affections. Both are believed to be of like etiology. The formation of the so-called enteritic membrane is attributed to excessive secretion of intestinal mucus of neurotic origin and as a result of which alone abnormal amounts of amorphous mucus are discharged. If, however, there be associated with this a spastic state of the bowel the excessive amount of mucus is compressed and band-like formations are expelled. If the discharge is attended with severe pain the assumption of a simultaneous sensory neurosis of the intestine seems justifiable. Westphalen calls attention also to the association that has been noted between membranous enteritis and intestinal sand, and of this he reports two illustrative instances.

The treatment of the disorder in question should be directed to the relief, by dietetic means, of constipation, when this is present, and substances rich in cellulose have been recommended for this purpose. Besides, mild enemata with simple infusions of warm water or with the addition of sodium chlorid, sodium bicarbonate, Carlsbad salt or aromatics may be given, or injections of oil. For the improvement of the nutrition starches and fats may be added to the food. Small amounts of oil may also be taken by the mouth, and at times bromid or opium, or belladonna may be administered with advantage. The state of the nervous system should be improved by exercise, gymnastics, hydriatic measures, and the like, and a partial or complete rest-cure may render valuable service.

1. Berliner Klin. Woch., 1901, Nos. 14, 15 and 16.
1. Wiener Med. Woch., 1901, No. 18, p. 857.

PNEUMOTHORAX IN THE ABSENCE OF DISEASE OF THE LUNGS.

Air may gain entrance into the pleural cavity as a result of perforating wounds of the chest, or of perforation through the diaphragm or the esophagus or the lung. The last-named event commonly occurs in consequence of disease of the lung or the pleura, but rarely it is due to rupture of air-vesicles from overdistention or from succussion, as in coughing, sneezing, laughing, and the like. Even under such conditions, however, it is probable that there must have been a weak point in the lung, perhaps the seat of emphysema or a pleural adhesion.

A remarkable instance of this sort is reported by Dr. B. Stiller,[1] who was called urgently to see a young man whom he had previously treated for a mild attack of nervous dyspepsia. The patient was found in great distress, in a semirecumbent posture, and it was learned that he had been seized suddenly an hour before with unbearable epigastric pain, after a violent paroxysm of sneezing. On examination, a large tumor was found in the epigastrium, yielding dulness on percussion, and which, it was concluded, was the liver, displaced downward and inward, and rotated forward upon its transverse axis. The right half of the chest was distended to its utmost, and immobile in respiration, with the percussion-note clear, but not tympanitic, on account of the great tension; vocal fremitus was absent. The heart was displaced to the left, the apex-beat being situated in the anterior axillary line. The respiratory murmur was amphoric on the right side, but metallic, ringing râles, as well as succussion splash, were wanting. There was no doubt that the condition was one of pneumothorax, with displacement of the liver from the concavity of the diaphragm. Suffering was relieved by injection and internal administration of morphin, and in the course of a day the liver had returned to its usual situation, though possibly a little lower than normal. In the course of a week, all signs of pneumothorax had disappeared. At no time was there any evidence of effusion into the pleural cavity. It is believed that, as a result of rupture of a subpleural air-vesicle, air was pumped with each inspiration from the lung into the pleural cavity, from which its escape was prevented by a valve-like formation, and finally causing the extreme displacement of the liver noted. The opening, fortunately, soon closed, and the air was speedily absorbed. So far as could be ascertained, the lungs were healthy.

1. The Lancet, June 8.

A REMARKABLE SURVIVAL OF SEVERE INJURIES.

What the human organism can stand in the way of injury, at least temporarily, is not yet absolutely determined. Every little while there appear presumably authentic reports of individuals surviving for hours, or even for longer periods, mutilations and injuries of supposed vital organs that are usually considered inevitably and immediately fatal. A recent case of this kind is reported by W. H. Clayton Greene,[1] that is of some curious interest. A man fell from a ladder and was impaled upon an area railing. He was removed to the hospital, and when seen a little later was pulseless, but the heart could be felt beating feebly and irregularly. There was a large gaping wound of the left hypochondrium, and it appeared that several ribs were fractured and hemorrhage had been excessive, but the condition of the patient prevented a detailed examination at this time. Under the influence of strychnin injections, hot applications, and saline solutions per rectum and the basilic vein, he rallied so that in less than one and a half hours the pulse was easily felt, and the wound was explored as far as practicable, but the source of the still-continued bleeding could not be definitely made out. About three and one-fourth hours after his reception an attempt was made to control hemorrhage; he was anesthetized and the wound again explored and found so extensive as to forbid surgical interference. The patient died nine hours after reception, and the autopsy revealed fracture of five ribs, perforation of both walls of the stomach from before backward, perforation and

laceration of the diaphragm, extensive collapse of the left lung, and perforation of the pericardium and left ventricle of the heart. While this case is not altogether unique in its severity, being, indeed, less obviously remarkable than that of the man who for some time survived being cut in two on a railroad in North Carolina, noticed editorially at the time in THE JOURNAL, it is still striking enough to call for attention. Perforation of the left ventricle by an iron fence paling, without immediate death, is certainly remarkable enough, but the wound was a lacerated or punctured one and probably valvular, so to speak, to some extent. The case, as Greene remarks, illustrates the vitality of the body after such injuries, and the value of normal salt solution, which in this case must have compensated largely for the loss by hemorrhage. Survival was impossible, but that he should have lived nine hours after such an injury seems almost miraculous.

Medical News.

(The usual amount of News has been crowded out on account of the Index.)

CALIFORNIA.

Dr. John M. Kane has been appointed city bacteriologist of Oakland, the appointment to take effect July 1.

Dr. Frederick W. Hatch, Sacramento, was reappointed general superintendent of the State Hospitals, June 10.

Dr. A. H. Giannini, San Francisco, who has recently returned from an eighteen-months' tour of Europe, was given a banquet by his professional and lay friends, June 8.

The College of Medicine of Southern California, Los Angeles, held its sixteenth annual commencement, June 13, graduating a class of eighteen. The Faculty address was delivered by Rev. George T. Dowling, on "Originality."

CONNECTICUT.

Dr. Ellen Pembroke O'Flaherty, Hartford, has been appointed assistant physician in the Sanatorium at Santa Clara, N. Y.

Prof. Edmund B. Wilson, of Columbia University, delivered the annual address in Medicine at Yale University, June 25, on "The Higher Claims of Minute Search in Biology and Medicine."

Hartford Medical Society received a donation of a portrait of the late Dr. Melancthon Storrs, painted by Charles Noel Flagg. William M. Storrs, in behalf of the other children, sent with the portrait a letter of presentation through Dr. George Shepherd, the president of the society.

New Britain Hospital has appointed the following on its staff for the ensuing year: Drs. Erastus P. Swasey, Lawrence M. Cremin, W. H. Barton and John E. Martin, acting staff; Drs. Robert M. Clark, Jay S. Stone and J. Norris Ball, Plainville, consulting staff; Dr. George J. Holmes, oculist and aurist; Dr. Kenneth E. Kellogg, neurologist, and Dr. Joseph B. Brocksieper, dermatologist. The directors have decided to equip a pathological laboratory.

FLORIDA.

The Board of Medical Examiners met at Tallahassee on May 14 and admitted two applicants to practice medicine in the state.

The Plant System Hospital, at Sanford, has been closed for reasons of economy. As the hospital at Montgomery, Ala., has also been closed, this leaves only two of the Plant system hospitals in operation, those at Waycross, Ga., and High Springs, Fla.

Central Florida is to have a national sanatorium for tuberculosis, located where the advantages of climate and water can be secured, without excessive humidity. Dr. James K. Crook, New York, has been making investigations throughout the state with this object in view.

Quarantine Station Leased.—The State Board of Health has leased to the United States treasury department, through the marine-hospital service, the quarantine stations, except Mullent Key stations in Tampa bay belonging to and operated by the State Board of Health of Florida, for a period of three years.

GEORGIA.

The Prison Commission has failed to sustain the charges of incompetency and neglect of duty made by the convict lessees against Dr. Hugo Robinson, of Albany, and he has been fully exonerated.

The Presbyterian Hospital at Atlanta has elected the following medical board: Drs. Marion McH. Hull, president, and E. Bates Block, general medicine and diseases of children; Drs. Stephen T. Barnett and Cyrus W. Strickler, general surgery; Drs. Edward C. Davis and James N. Ellis, gynecology and obstetrics; Drs. Walter B. Emery, secretary, and James McFadden Gaston, Jr., genito-urinary surgery; Drs. Arthur G. Hobbs and James M. Crawford, eye, ear, nose and throat; Dr. Michael Hoke, orthopedic surgery, and Drs. Miller B. Hutchins and John L. McDaniel, diseases of skin and nervous system. The hospital will be opened July 1.

ILLINOIS.

Dr. Lincoln M. Bowman has been elected physician of Alton, and Dr. Edward C. Lemen, of Upper Alton.

Dr. R. Homer Mead, Camden, has beeen appointed superintendent of the warden's part of the state penitentiary at Chester.

Dr. Edward L. Birch, Robinson, has been appointed assistant physician of the Illinois Northern Hospital for the Insane at Kankakee.

St. Francis Hospital, Freeport, received $10,000 from the estate of the late Dr. W. S. Caldwell. It is directed that this sum be invested and its interest used for the treatment and care of the sick poor.

GENERAL.

Dr. Henry L. E. Johnson, Washington, D. C., secretary of the Board of Trustees of the AMERICAN MEDICAL ASSOCIATION, was married to Miss Eugenie Taylor, also of Washington, June 19. On their return from their wedding trip Dr. and Mrs Johnson will occupy their new residence at 1821 Jefferson Place.

Congress on Tuberculosis.—It is much to be desired that a large contingent from the United States should participate in the work of this Congress, which will be held in London, July 23 to 26. Many prominent physicians have signified their intention of joining the Congress. Members of the profession wishing to do so should send their names, inclosing five dollars, to Dr. St. Clair Thomson, 20 Hanover Square, London, W., England.

The "Atlanta Institute of Christian Science," which applied for a charter, has been denied recognition by Judge J. H. Lumpkin, who holds that "Christian Scientists" cannot practice their treatment of diseases in the state of Georgia without having regularly graduated in medicine or passed an examination before the medical examining board, the same as other physicians. He holds that, according to the decision of a case in the Supreme Court of Nebraska, Christian Science is the practice of medicine, and that the practice of medicine in Georgia, according to the state law, must be accomplished by persons who are regularly graduated from a medical school.

Current Medical Literature.

Titles marked with an asterisk (*) are noted below.

Medical News (N. Y.), June 15.

1 *Decortication of the Lung for Chronic Empyema. George Ryerson Fowler.
2 *A Study of Some Complications and Sequelæ of Typhoid Fever. H. A. Hare and H. R. M. Landis.
3 "The Porro-Cesarean Operation," with Report of Two Successful Cases. James H. Glass.
4 *The Treatment of Scarlatinal Nephritis. Charles Gilmore Kerley.

American Medicine (Philadelphia), June 15.

5 *Pulsation of the Uvula in Aortic Insufficiency. David Riesmann.
6 *Prevention and Cure of Post-operative Hernia. James E. Moore.
7 A Few Useful Points in the Symptomatology of Eye Diseases Applied to General Practice. Henry Bassett Lemere.
8 *Formalin in the Treatment of Suppurative Otitis Media. Nathan G. Ward.
9 Synchronous Amputation of Both Thighs for Gangrene of Feet under Special Cocainization. George G. Hopkins.
10 *Permanent Gold Preparations. Emma L. Billstein.

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GENERAL INDEX.

Use of the index will be facilitated by bearing in mind that subjects are frequently given under two or more headings, e. g., brain, cerebral, tumors, etc.; heart and cardiac; cirrhosis, liver and hepatic; child, children and infant; gland, thyroid, etc. Often, too, writers treat of the eye, ear, nose and throat under one head, etc., and the titles do not always permit of indexing under the several headings. The "General Index" contains only titles of articles, editorials, society reports, abstracts, and miscellaneous matter appearing in The Journal; the book notices, deaths, societies, marriages, authors, and titles of articles mentioned in the "Current Medical Literature" department are indexed and arranged under their separate headings instead of in the body of the "General Index."

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Burns, W. B., (146) 920, (49) 1142
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Burrell, H. L., (8) 1141
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Caldwell, W. S., (121) 1276
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Pepper, W., (109) 841
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Percy, J. F., (94) 992
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Perrier, J., (43) 597
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Perry, R. St., (82) 1276
Peter, L. C., (48) 991, (101) 1071
Peters, G. A., (95) 687
Peters, L., (42) 919
Peters, U. J. W., (158) 841
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Pirnat, F. H., (111) 1349
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Polk, W. M., (22) 1141
Pond, A. M., (3) 1141
Pond, E. A., (3) 468
Pond, H., (120) 404
Pool, J. E., (15) 765
Poole, W. H., (55) 525
Poore, G. V., (114) 841
Pope, C., (110) 345
Porteous, W. N., (36) 919
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Porter, J. L., (115) 841
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Price, M. G., (139) 992
Price-Brown, J., (86) 992
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11 An Improved Bedstead for Invalids. E. E. Munger.
12 Excessive Eosinophilia in Trichiniasis. A. J. Patek.

Medical Record (N. Y.), June 15.

13 *A Note on the Spread of Yellow Fever in Houses. Extrinsic Incubation. H. R. Carter.
14 *On the Origin of Cancer; What Remains to Be Demonstrated. Samuel W. Bandler.
15 *The Redundancy of the Pre-insula in the Brains of Distinguished Educated Men. Edward A. Spitzka.

New York Medical Journal, June 15.

16 An X-ray Study of the Causes of Disability Following Fractures Involving the Elbow Joint. Samuel Lloyd.
17 *A Modified Urethral Dilator-handle. Ferd C. Valentine.
18 Hyperacidity (Superacidity, Hyperchlorhydria, Superaciditas Chlorhydrica); A Clinical Study. (Continued.) H. Illoway.
19 Penetrating Wounds of the Abdomen. Russell S. Fowler.
20 Paramyoclonus Multiplex. L. J. Morton.
21 A Case of Cerebellar Apoplexy with Autopsy. Leonard Weber.

Boston Medical and Surgical Journal, June 13.

22 *Internal Medicine in the Nineteenth Century. N. S. Davis, Jr.
23 *Some Observations on Chronic Seminal Vesiculitis. Arthur L. Chute and Richard F. O'Neil.
24 *Iodophilia. Theodore Dunham.
25 Cystic Tumor of Median Nerve; Operation: Restoration of Function. A. S. Hartwell.

Philadelphia Medical Journal, June 15.

26 *The Topical Treatment of Focal and Jacksonian Epilepsy. J. William White.
27 *Theoretical and Practical Considerations on the Treatment of Jacksonian Epilepsy by Operation; with the Report of Five Cases. (To be continued.) James Jackson Putnam.
28 *What I Have Learned from 161 Operations for the Relief of Senile Hypertrophy of the Prostate Gland. (Continued.) Orville Horwitz.
29 The Value of the Combined Medical and Surgical Clinic to the Student. Robert G. LeConte.
30 A Case of Abdominal Pregnancy. Augustus C. Behle.
31 Specialism and Some of Its Relations to the General Practice of Medicine. Henry Wallace.

Cincinnati Lancet-Clinic, June 15.

32 *Diagnosis of Typhoid Perforation. Mark A. Brown.
33 Surgical Interference in Typhoid Perforation. N. P. Dandridge.
34 The Curette and Packing in Endometritis. J. M. Withrow.

St. Louis Medical Review, June 15.

35 *Insanity in Women from the Gynecologic and Obstetric Point of View. A. Lapthorn Smith.
36 A Case of Puerperal Sepsis. Willis Hall.

Medical Council (Philadelphia), June.

37 Disorders of the Sexual Function in Man. A. H. P. Leuf.
38 The Biography of Culex. J. J. Hanley.
39 Idiosyncrasies. Carroll Kendrick.
40 Some Reminiscences from My Obstetric Experience. W. H. Thomas.
41 Diphtheria Successfully Treated with Pilocarpine. J. A. Muenich.
42 The Injection Method for the Relief and Cure of Hernia. C. Fletcher Souder.

American Journal of Insanity (Baltimore), April.

43 Some Points in the Treatment of the Chronic Insane. Francis O. Simpson.
44 *Notes on the Contracts and Torts of Lunatics, with Special Reference to the Law of Maryland. William H. Buckler.
45 Heredity. J. T. Searcy.
46 Insane or Criminal? George J. Preston.
47 Death of an Insane Man from Fracture of Skull and Hemorrhage of the Brain; Skull Abnormally Thin. A. R. Moulton.
48 The Relation of Mental Content to Nervous Activity. E. B. Delabarre.
49 *Mental Therapeutics in Nervous and Mental Diseases. Richard Dewey.
50 Signs of Degeneracy and Types of the Criminal Insane. Chas. A. Drew.

Journal of Cutaneous and Genito-Urinary Diseases (N.Y.), June.

51 Therapeutic Notes on Sulphur Cream, Goose Grease, and Crude Petroleum. George Thomas Jackson.
52 *A Modification of Cock's Method of Performing External Urethrotomy Without a Guide. Percy R. Bolton.
53 Case of Prostatectomy. James Bell.
54 Multiple Nodular Melanosarcoma of the Skin from a Nevus. A Ravogli.

St. Louis Medical and Surgical Journal, June.

55 A Case of Disseminated Seborrheic Epithelioma. A. H. Ohmann-Dumesnil.
56 Fever. Benjamin H. Brodnax.
57 Observations and Tabulated Report of the Result of 150 Operations for Appendicitis. Leon Brinkman.
58 A Contribution to the Modern Treatment of Piles. Dr. Jedlicka.

Cleveland Medical Gazette, June.

59 *Diagnosis of Meningitis. Charles J. Aldrich.
60 *Albumosuria as a Diagnostic Aid in Diseases of the Osseous System. Walter G. Stern.
61 *Albuminuria of Adolescence and Cyclic Albuminuria. H. J. Lee.

Southern Medical Journal (La Grange, N. C.), May.

62 Circumcision. Israel Brown and Stanley H. Graves.
63 Malaria: A Clinical Report. J. W. P. Smithwick.
64 Cholera Morbus. A. S. Buchanan.
65 Treatment of Opium and Morphin Habit. J. W. P. Smithwick.
66 *Abdominal Versus Vaginal Hysterectomy. Henry O. Walker.

Nashville Journal of Medicine and Surgery, May.

67 A Case of Traumatic Separation of the Symphysis Pubis Complicated by Rupture of the Bladder and Urethra, and Extensive Urinary Infiltration—Operation and Recovery. Charles S. Briggs.
68 Jacksonian Epilepsy, with Report of a Case. E. G. Wood.

Charlotte Medical Journal, May.

69 Materia Medica and Therapeutics. J. A. Reagan.
70 The Use of Continuous Silver Wire Sutures in the Closure of Abdominal Incisions and the Radical Cure of Hernia. L. B. McBrayer.
71 Dacryocystitis. W. W. Duson.
72 The Treatment of Alcoholism. H. L. Baird.

AMERICAN.

1. **Decortication of the Lung.**—Decortication of the lungs is a term applied by Fowler for designating the procedure intended to relieve the lung of its environment in cases in which expansion is prevented or interfered with by the presence of greatly thickened pleural covering. He reproduces here in abstract a case of the first observation of this kind published by him in 1893. He reviews the literature and experience with the operation so far as known up to the present time. His conclusions are: 1. Decortication of the lung is an operation adapted to all cases of old empyema in which extensive and pre-operatively discoverable tuberculous lesions of the lungs are not present, and in which the patient's condition will permit of a major operation. 2. It may be advantageously substituted for Estlander's operation in the majority of instances in which the latter has been considered, up to the present time, as being indicated, since it is more a rational procedure in that it combines the advantages of restoration of function of the lung, so far as this is possible, with closure of the empyemic cavity. 3. It should replace Schede's operation in all cases. 4. The method by extirpation of the diseased portion of the pleural membrane, including the visceral, cortical, and diaphragmatic portions, is the operation of choice. 5. Failing this, visceral pleurectomy should be selected. 6. Pleurotomy, with simple detachment of the visceral layer of the diseased pleural membrane, gives sufficiently good results to warrant the surgeon in resorting to this procedure in cases in which the condition of the patient will not permit of the application of the other and more desirable methods. 7. Whatever operative method is adopted, as complete access to the cavity of the chest as possible should be obtained, and rapid closure of the opening in the chest-wall afterward secured, since the complete re-expansion of the lung must depend largely upon the normal respiratory movements. 8. Pulmonary or respiratory exercises should not be neglected in the after-treatment, since these aid greatly in the restoration of the function of the lung.

2. **Typhoid Fever.**—The complications and conditions noticed in the paper of Hare and Landis are those of typhoid fever in pregnancy, the frequency of typhoid in children and its symptoms in them as distinct from those in the adult, especially the temperature, eruption, and circulatory and nervous symptoms. He also discusses the facts in regard to typhoid fever in advanced years, the different forms of onset of the disease and the alimentary, respiratory, nervous and renal conditions at the beginning of the case.

4. **Scarlatinal Nephritis.**—After noticing some errors of treatment for the sequelæ of scarlet fever in its convalescence, Kerley asks: What is to be the management of a case in which exudative glomerular nephritis of average severity in a child,

with puffiness of the eyelids, edema of the feet and ankles, scanty, high-colored urine, fever, headache, and perhaps nausea, usually at three or five weeks after disappearance of the rash? The first step refers to the diet. Milk, broths, and thin gruels only should be given. The bowels should be moved two or three times daily. Small doses of calomel, one-tenth of a grain per hour, or citrate of magnesia are recommended for this purpose. Small doses of aconite, one-fourth minim every two hours for a child 3 years old, is prescribed usually as a routine measure, and he has found it a very useful drug in producing diaphoresis. In case this fails hot air is brought into use, being conducted under the bedclothes from a lamp, and if this fails hot packs may also be employed, while great care should be exercised as regards exposure. A very important remedy which he recommends is hot-water flushing of the colon; this he thinks is of more value in restoring the kidney function than any other measure. It may be used to advantage when the urine first becomes scanty, as well as when convulsions are threatened or present. For a child 3 years of age, 16 to 24 ounces of normal salt solution at 110 F. is introduced by a rectal tube, which should be inserted at least ten inches. The object is to have the water retained and the higher it is introduced the better. A pint to a pint and one-half every six hours does best in most cases. The child must be kept in bed until the urine has been normal for two weeks.

5. **Uvular Pulsation in Aortic Insufficiency.**—Riesman calls attention to the fact that pharyngeal pulsation in aortic insufficiency was first brought to the attention of the profession by F. Mueller in 1889 and that little reference to it has since been made. He reports two cases in which the phenomenon occurred. It is, of course, of the same nature as the capillary pulse and has no special diagnostic value, but the knowledge of its existence adds one more point to be looked for in the critical study of a case and sharpens the powers of minute observation.

6. **Post-operative Hernia.**—After first noticing a case of post-operative hernia, Moore gives the following method, which he has used for several years, in closing the abdominal wound: The peritoneum is first closed by a running stitch of medium-weight catgut. Silkworm-gut sutures are next passed through all of the tissues except the peritoneum by means of a full curved needle of a size suited to the thickness of the abdominal wall. The needle passes from without inward through the integument, fascia, muscle and deep fascia, coming out next to the peritoneum. It then passes from within out through the inner fascia, muscle, outer fascia and integument. In a very thin abdominal wall the needle can be passed through both edges of the wound at one sweep, but in most cases it is better to take them separately. These stitches are placed about a half inch apart. The fascia of the external oblique is next united by a running stitch of medium-weight catgut. All the ends of the silkworm-gut are now caught and pulled upon at once so that they are made taut, after which they are tied lightly. Extra skin sutures are applied when needed. The advantages are, that the peritoneal cavity is closed without delay, and there is no undesirable material left in the tissues to make future trouble. Suturing of the outer fascia gives such support that the silkworm suture need not be tied so tightly as to cause necrosis. The operation obliterates any dead space and yields permanently satisfactory results.

8. **Formalin.**—The use of formalin in the treatment of suppurative otitis media is advised by Ward. He finds that by the judicious use of formalin the following results may be obtained: 1. Fetid odor quickly disappears. 2. There is an early cessation of the discharge. 3. It protects against the formation of granulations, and small granulations are destroyed by alcoholic solutions. 4. It promotes healing of ulcerated mucous membrane, skin abrasions, and inflammation of the external auditory canal. 5. It retards, but does not entirely check, bone necrosis.

10. **Permanent Gold Preparations.**—The usual temporary nature of gold stain on nervous tissue is first mentioned by Billstein, who reports her results with a mixture made by 8 parts of a 1 per cent. solution of gold chlorid and 2 parts of formic acid boiled three times and then cooled. The tissue is put in the cold material, which must be kept in the dark. After one hour it is washed in distilled water and placed in a mixture of 10 parts of formic acid and 40 parts of distilled water and exposed to diffuse daylight. The reduction occurs at 24 to 48 hours, when the violet tissue is transferred to 70 per cent., and after 24 hours to 90 per cent. alcohol and kept in the dark for at least one week. It is then ready for final manipulation and may be teased and mounted in acidulated glycerol or imbedded and cut into sections. This method has been attributed to Stöhr, and is similar to Ranvier's technique, "Procede de l'or bouilli." Stöhr, however, advises longer boiling of the gold chlorid and formic acid mixture. The author has found the stain to remain permanently two and three years, and apparently it will endure indefinitely.

13. **Yellow Fever.**—Carter's article deals with the subject of house infection and gives illustrations showing the interval between the infection and the first appearance of yellow fever. The article was mainly written before the recent publication of the observations of Reed and Carrol at Quemados, and he says that they agree entirely with his result, the incubation after the mosquito bite being only slightly longer than that which he found from apparently infected houses, and Reed's theory agrees absolutely with the conclusions of this paper.

14. **Cancer.**—Bandler reviews the recent experimental researches on the origin of cancer. He quotes Cullen as stating that Gaylord has not in any case experimented with the cure culture and that the recovery of the organism from the cancer produced is hardly touched upon by him. He says, however, that as Gaylord's communication is preliminary the complete work may yet solve these problems. The larger part of his paper is a review of Leopold's work on the production of cancer from the injection of blastomycetæ and he admits that the causal relation of these organisms to the growths produced in animals must be granted. The decision concerning the character of these neoplasms and their actual relation to carcinoma and sarcoma is a question yet to be settled.

15. **The Pre-insula.**—The relation between the development of the insula and mental development is the subject of Spitzka's article. E. C. Spitzka has shown in 1880 that the insula had a greater development in the porpoise than the human species, but it appears that the greater part of this development was in the post-insula, and the theory was offered that it had to do with the excessive development of the functions of audition and equilibrium in these mammals. The observations of Waldschmidt and Donaldson on the insula of deaf mutes are referred to, and also the theory that exposure of the insula indicates defective brain development. This last is apparently contradicted by results of examination of the brain of the Seguins previously published by Spitzka and it is possible that a similar exposure of the insula exists in the brain of Chauncey Wright, which is being examined by B. G. Wilder. In the human subject the development is greatest in the pre-insular portion and the conclusions to be drawn from the Seguin brains as correlated with their known abilities are: 1. In the highly intellectual (for example, the two Seguins), owing to the excessive growth and development of the left pre-insula causing a displacement of the opercula, thrusting them apart, as it were, and even though the latter be very well developed. 2. In the defective, exposure of the pre-insula is due to deficient development of the opercula, and because these fail to approach each other. In such cases the insula itself is, with a single exception in the series studied by me, of inferior development, indicated not only by the soundings of the Sylvian cleft, but also by the flatness of configuration, and lesser area of the insular cortex. A possible additional factor is that the deeper and more numerous the infractuosities of the insula the more numerous are the important branches of the medicerebral artery and the greater their caliber. Since the greater blood supply is presumably a condition of higher potency of function, insular development *per se* is an expression of general development in this other respect as well as in the purely morphologic one. He asks, putting the facts together of the relative proportions of the two extremities of the insula in the porpoise and in man, and in the light of Waldschmidt's

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observation, would it be rash to propose that the post-insula shares in its development that of the auditory sense center, by virtue of association neurons with short axons, while the growth of the pre-insula is more in consonance with that of the true "speech-center" in the subfrontal operculum? After all, the development of the pre-insula is only an intense expression of that feature by which the human brain excels all other animals; for in no lower form do we find the insula so fully developed in its cephalic region.

17. **Modified Urethral Dilator-handle.**—The modification proposed by Valentine consists in putting the dial on the top of the handle instead of the side, and having two heavy metal projections for the operator's thumb and index finger. The advantages are that the dial is continuously under the operator's eye and out of the range of the patient's, and the improved mechanism does not increase the cost.

22. See THE JOURNAL of June 8, p. 1606.

23. **Chronic Seminal Vesiculitis.**—Chute and O'Neil call attention to the importance, only recently recognized, of seminal vesiculitis and describe its symptoms, diagnosis and treatment. Among the symptoms they specially mention are feelings of vague discomfort in the rectum and perineum, pain and discomfort on defecation, persistent discharges, especially those containing small comma-shaped shreds from the prostatic urethra, sometimes frequency of micturition, tenesmus, etc. The direct symptoms are for the most part urinary in character and not particulary distinctive. The reflex symptoms are those of sexual neurasthenia. The most characteristic symptoms are irregularity in the function of erection. A combination of neurasthenic symptoms with these latter is almost pathognomonic. The details of physical examination of the prostate, etc., are mentioned. The treatment which has given the writer the best results is massage of the vesical ducts and of the prostate as well. He warns against advising sexual indulgence as a therapeutic measure. It is probable that a certain number of cases of impotence and many of sterility are due to this condition, which gives its treatment wider importance than that mere relief of the discomfort. He would strongly advise examination by rectum of all patients with urethral disease not progressing favorably, particularly those presenting so-called neurasthenic symptoms.

24. **Iodophilia.**—This term is coined by Dunham to designate the reaction shown by the blood, in which the polymorphonuclear neutrophiles take on a reddish-brown coloration, when examined with a solution of iodin dissolved in iodid of potassium. The solution is made up as follows: Three parts of potassium iodid are dissolved in 100 parts of water. In this is dissolved 1 part of iodin. The resulting solution is thickened to a syrupy consistency by the addition of gum arabic and the blood smear is mounted in a drop of this syrup and a bit of filter paper placed at the edge of the cover glass to absorb the excess of fluid. The specimen is then ready for examination with an oil-immersion lens. The reaction is apparently always present in progressive suppurations and in progressive pneumonia and may occur in a few other diseases, such as grave anemias, leukemia, etc. Its value, however, lies in cases of doubtful suppuration and doubtful pneumonia. He gives illustrations of its use in cases of abscess and inflammation of the lungs.

26. **Focal Epilepsy Operations.**—White refers to a former article of his on the influence of operation *per se*, and discusses the rationale of the effect. The problems finally took this shape in his mind: When can subjects of epilepsy receive, without undue risk of life or health, the benefit of both operative interference and sedation of affected brain area? 2. Can operation be based on any but empirical grounds? If on the latter only does the evidence warrant its continuance? Is there any means of securing sedation, that is, of applying the general therapeutic principle of rest in such a way so that natural processes may have an opportunity to effect a cure without at the same time disturbing or interfering with the general health. He decides at once that as regards the idiopathic epilepsies and pseudo-Jacksonian cases, the answer to these questions should be in the negative, but as to true focal epilepsy, whether traumatic or not, the case may be slightly different. In fact the results of operation, while more encouraging, are not sufficiently so to justify us in ignoring the greatly increased risk and post-operative paralysis following excision of the center, without which trephining becomes an incomplete and an unsatisfactory operation. He was therefore led to try the following method: The affected center is, of course, determined in advance by the most careful study and observation of the case. Its relation to the cranium is indicated by a silver or iodin mark upon the shaven scalp two days before the operation. The scalp is sterilized and re-sterilized three times at intervals of twelve hours, not only before the trephining, but also before each subsequent application of the treatment. A horseshoe-shaped flap is raised and a half-inch button of bone removed with a small trephine. The dura is left intact. Thirty minims of a sterile 2 per cent. solution of eucain is then injected into the brain substance at the center of the trephine opening, the point of the needle being introduced about three-quarters of an inch. The needle is gradually withdrawn as the last ten minims of the solution are injected. The flap is replaced. The patient is returned to bed, and on the day of operation, and the following day, should receive full doses of bromids. At intervals, the proper length of which can only be determined by experience, the scalp having been sterilized as above, the injection is repeated. The patient should be kept in bed at least four hours after each injection and should take bromids for from one to two days." He is not convinced that this method has any additional value, but he reports two cases in which it was tried at the University Hospital. He admits that this can not be said to establish even the entire safety of the procedure, as convulsions in Case 2, which followed one of the injections, were of marked severity. Neither can it be said that the results obtained were noticeably better than those seen to follow the very miscellaneous procedures that have been reported, but he still thinks that the possibilities of benefit would justify him in placing it conservatively before the profession.

27. **Jacksonian Epilepsy.**—The views maintained by Putnam are: 1. that operations of many different sorts are of value; 2. that the beneficial action of these operations, although complex in character, is mainly due to the induction of a temporary inhibition of the morbid action of the cortex, which permits of the establishment of a more normal tendency; 3. that the removal of the apparently normal cortex is rarely advisable, and, when beneficial, acts mainly as above indicated; 4. that the cause of the persistence of the "epileptic habit" is not to be sought alone in anatomic peculiarities of the brain, but that it shares the vitality and independent endurance of memories in general. Also, the symptom-groups which present themselves after cortical lesions conform, in general, to certain special types, which recur without being closely dependent on the localization of the cerebral injury. These symptom-groups represent, in fact, efforts at the formation of a new equilibrium on the part of a being endowed with consciousness and memory on the one hand, and with a complex brain mechanism on the other. The principle on which this readjustment goes on in cases of actual cerebral lesion, is analogous to that which is operative in "hysteria."

28. **Prostatectomy.**—Horwitz' conclusions regarding prostatectomy are: 1. With the exception of ligation of the internal iliac arteries, prostatectomy is the most dangerous of any operation that has been recommended for the relief of prostatic obstruction due to hypertrophy. 2. Suprapubic prostatectomy is the safest method, especially if combined with perineal drainage. 3. The best period to select to perform this operation is early, before the break-down of catheter life and serious complications have supervened. 4. Either an atonied or contracted bladder of long standing, associated with chronic cystitis, attended by the formation of sacs, or pouches, are contra-indications for the operation. 5. A partial prostatectomy is indicated in those cases where a valvelike lobe exists, which interferes with urination, or where there is partial hypertrophy of one of the lobes. 6. A complete prostatectomy is indicated where a hypertrophy of the three lobes has taken place, especially if the condition is associated with tumor for-

mation, projecting well back into the bladder, or has given rise to a stenosis of the prostatic urethra. 7. Perineal prostatectomy is best suited to those cases where the enlargement of the lateral lobes has a tendency to grow towards the rectum, or obstruct the urethra. 8. When performing a perineal prostatectomy the semicircular incisions advocated by Pyle, or the transverse cut of Worholm, is the most satisfactory. 9. The removal of a portion of a small, hard, fibrous prostate gland by means of the perineal route is a very difficult operation. There is danger of not only extirpating the entire gland, but the prostatic urethra as well.

32. **Typhoid Perforation.**—Typhoid perforation is discussed by Brown. It occurs as a rule at the end of the second or beginning of the third week and special attention should be given at this time for its occurrence. The first symptom is pain, sudden in its onset, agonizing in character, though this symptom may be dependent on other causes, even in cases of typhoid. A sudden and decided drop in the temperature usually follows, though not invariably, and it may be so transitory as to escape notice. The pulse usually becomes increased in frequency and decidedly weakened, but not wiry until actual peritonitis has set in. The most important part of the symptomatology is objective. With an opening between the bowel and peritoneal cavity there will be a more or less rapid outpouring of gas and fluid, gradually decreasing as the pressure becomes lessened. This gaseous distention of the abdomen, palpation signs, etc., are all noticed at length. Auscultation is of little value. A blood examination may reveal slight leucocytosis. The facial expression, sweating and decubitus indicate the passage into the third stage. The combinations of symptoms are, he says, generally so varied that it is almost impossible at times to diagnose the conditions early enough to allow operative interference with any chance of success.

35. **Insanity in Women.**—Lapthorn Smith reviews the work of Hobbs, Hall, Rohe, Bucke, and others, and concludes that insanity in the majority of cases is not due to organic brain disease, but to the functional disorders of diseased circulation and its circulating fluid, and that this in many cases in women is caused by reflex irregularities from pelvic organs. He thinks it is the duty of the family physician to examine every insane woman in his practice, or have her examined by a gynecologist, and remedy any pelvic diseases that may exist. This should be done systematically also in asylums. He makes the statement in conclusion, that in view of the number of women that become insane from uremia some care should be exercised by the practitioner in preventing this condition and that physicians should, when permitted, with the advice of one or two colleagues, empty the uterus.

44. **Contracts and Torts of Lunatics.**—Buckler sums up the Maryland law, and says that for the present the rule undoubtedly is that whenever a person is injured by the act of a lunatic, he may sue and recover damages from the lunatic, unless malicious intent is a necessary ingredient in the tort. There seems, however, to be a tendency to depart from the rashness of this rule, and to place the tortious acts of lunatics on the same footing as those of sane persons which occur as the result of an inevitable accident.

49. **Mental Therapeutics.**—The central idea of Dewey's article is that the cure of many nervous and mental diseases consists in a process replacing in the patient a natural and healthy mind and healthy association, replacing morbid ideas with normal ones, forming new habits by a process that may be in some cases likened to education.

52. **External Urethrotomy.**—Where the use of a guide for urethrotomy becomes impossible, as with impermeable stricture or complex division of the urethra, the operation is often tedious and difficult. The appliances that are available for this purpose and have been instituted have their disadvantages. Retrocatheterization implies extra mutilation and adds somewhat to the danger. The Wheelhouse operation is of limited practicability; it can only be performed where the stricture is still permeable and many times can not be carried out even in these cases. The Cock operation has a wider field, but Bolton suggests a method, whose principles are the same as those underlying the Cock operation, but differing in details. He describes it as follows: "The patient may be placed in the lithotomy or knee-chest position. A curvilinear transverse incision is made across the perineum, the convexity looking forward or backward and the tendinous center of the perineum exposed. The attachment of the sphincter ani to this point is divided and reflected and the triangular ligament thus exposed incised transversely. The anterior fibers of the levator ani passing beneath the prostate to the rectum now come into view. These, together with the rectum, are next pushed backward and the prostate exposed. The exposed surface of the prostate is now cleaned and its apex identified. No harm can accrue from incision into the floor of the prostatic urethra anterior to the veru montanum, and incision made into this part of the prostate is sure to enter the urethra behind its point of stricture. The anterior quarter inch of the apex of the prostate is accordingly incised longitudinally in the median line, the urethra opened and the incision then prolonged forward as far as desired, guided, if necessary, by a probe or director suitably bent and introduced into the urethra from behind forward." He says this method, while a little more elaborate than the original operation, does not seem to him especially difficult and will be found useful in recent ruptures of the urethra, and in strictures uncomplicated by extravasation of urine or perineal abscess. He would hesitate to make use of it in cases of infectious inflammation or necrosis of the perineal tissues, on account of the larger wound surface exposed to infection and the risk of infection of cellular tissue, above the transverse ligament between the rectum and bladder.

59. **Diagnosis of Meningitis.**—The various symptoms indicating the presence of meningitis are reviewed by Aldrich, according to their various diagnostic values: the widely varying onset, head pains, convulsions, facies, mental state, pulse, temperature, respiration, etc., and he mentions one respiratory change which he has observed so often that he believes it of diagnostic value. In normal inspiration the adominal walls are expanded, but retracted on expiration. In meningitis, however, there is a retraction of the walls during inspiration and the descent of the diaphragm, probably due to hypertonus of the muscles, which is a constant and early symptom. Vomiting, abdominal symptoms, muscular rigidity, urinary retention, Kernig's sign, cutaneous eruptions, etc., various sensory symptoms, leucocytosis, etc., are mentioned. He believes that in lumbar puncture we have a great step towards accuracy in the diagnosis, and calls attention particularly to a condition of the serum which has been observed by him since 1898. When a test tube containing a column of cerebrospinal fluid from a case of meningitis is allowed to stand from twelve to twenty-four hours without agitation, a thin filament of fibrin forms in the center of the column of fluid, and seems to be suspended from a delicate pellicle at the top and extends to the bottom. Lifting out this fibrin with a platinum loop and with it spread out on the cover glass, cells of diplococci were revealed. He thinks that this observation is of special value where the use of the centrifuge, and microscope and culture studies are not available. The same symptom has been noticed by Breuer in Vienna and the same diagnostic importance attributed to it.

60. **Albumosuria.**—Stern calls attention to the presence of albumose in the urine as an indication of osteomalacia and bone tumors. Not all cases of osteomalacia or multiple bone tumors show this symptom; sometimes it may be absent during the short time the case is under observation. Nevertheless, in a large number of cases it gives the only possible indication of the diagnosis.

61. **Cyclic Albuminuria.**—The title of this article, Lee remarks, implies two distinct conditions, which, however, are practically one in all essential points. The albuminuria of adolescence is always cyclic, and cyclic albuminuria occurs most often about the period of adolescence, and it is no doubt the same as that which more rarely occurs later in life. Functional albuminuria is the term usually employed. It is an important condition. When it persists after 25 years of age he would not consider the case a good insurance risk. The

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etiology is obscure. The condition produces no systemic symptoms and is often accidentally recognized, but many cases probably go unrecognized. In a typical case the albuminuria is absent in the morning, but appears after eating and after muscular exercise or cold bathing, and reaches the maximum the latter part of the day and disappears entirely again. Exceptionally it may be present all the time. The points of diagnosis are the small amount of albumin, absence or rarity of casts, lack of retinal changes, of cardiac hypertrophy, of increased arterial tension, of exaggeration of aortic second sound and dropsy. If after repeated observations, say for over six months, these symptoms exist, we have a case of so-called functional albuminuria. The prognosis is favorable, the albumin usually disappearing before adult life. The treatment consists chiefly in attention to existing anemia, diet, etc.

66.—See abstract in THE JOURNAL, xxxv, p. 1046.

FOREIGN.

Bulletin de l'Academie de Med. de Paris, May 28.

Neuralgia in Connection with Latent Aneurysms of the Aorta. H. HUCHARD.—The portion of the aorta between the fourth dorsal vertebra and the tenth is comparatively isolated from the surrounding organs, and an aneurysm may grow to a large size without causing symptoms. The descending thoracic aorta is, therefore, the latent zone of unrecognized aneurysms, of mistakes in diagnosis. The abdominal aorta also occasions similar mistakes. There are, however, certain pains sometimes connected with these latent aneurysms, which have a peculiar clinical character and establish a strong presumption in favor of the latent lesion. The seat of the pains is variable and may suggest a simple rheumatism of the shoulder, a rebellious intercostal or thoracobrachial neuralgia; but close study will show that the pain is not that of true neuralgia. The patients suffer for months, for years, from a single, fixed pain in the shoulder or supraspinal, subclavicular or interscapular region. In other cases, the pain occupies one entire side of the thorax and neck; it may be deeper in the chest, starting at the upper third of the sternum and passing to the spine, simulating angina pectoris. It may, in other patients, invade the arm and extend along the neck to the side of the head. It may affect the nerves of the cervical plexus and induce, by reflex action, contraction of the muscles of the neck, suggesting a simple torticollis. In other patients the pain may appear in one of the intercostal spaces, may be so severe as to interfere with respiration, or it may be bilateral, in girdle form, as if from a spinal affection. The pain is almost always continuous, permanently at the same spot, not paroxysmal and very rarely has the lancinating character of true neuralgia. The diagnosis of these pains in the cases reported has ranged from compression of the spine to simple rheumatism, but the appearance sooner or later of a pulsating tumor, or sudden death from hemorrhage, showed the error. Another peculiar feature of these pains, which are the premonitory symptoms of a latent aneurysm, is the fact that they can be exaggerated or diminished by changes of position. If the radioscope shows a tumor in the mediastinum, it must be borne in mind that aneurysms alone give rise to these pains, remarkable for their obstinacy and long duration, their abnormal intensity and rebelliousness to all the usual medication. The mechanism is probably a kind of uninterrupted pounding from the developing aneurysm. Fournier has seen a case of sudden, inexplicable pain in the arm in an old syphilitic vanish after specific treatment. Three years later an aneurysm of the aorta was observed and this also vanished under mercurial treatment. Huchard described several cases to illustrate the variety of pains that might be encountered with latent aneurysms. The pains that accompany an aneurysm of the abdominal aorta may simulate lumbago or nephritic colic, or girdle the trunk or follow the course of the ureters or spermatic cord.

Presse Medicale (Paris), May 29.

Preservation of Glycogenic Function of Liver in Cirrhosis. BRAULT.—The writer's studies on glycogenesis in neoplasms have been mentioned in THE JOURNAL, xxx, p. 877, and xxxv, p. 914. He showed that it was possible for a tumor in the liver to be producing glycogen while the liver cells were incapable of glycogenesis at the time. He now demonstrates that during the evolution of cirrhosis many of the liver cells retain their reserves of glycogen intact, and renew them, even those cells which are isolated. The cells are separated into groups or isolated by the progress of the morbid process, but the strips or rings of sclerosis, hitherto considered destructive to the trabeculæ and liver cells, are in reality so passive that the cells in contact with them or isolated in their depths, retain their normal histochemical properties and especially their glycogenetic activity. This integrity of the cells explains the latent or compensation period of cirrhosis, the respites and the cases in which the destructive process may be arrested for years. It also shows the possibility of the cure of cirrhosis in certain cases and survival with a liver, cirrhotic and indurated, but still functionally sufficient. Brault's latest research also demonstrated that glycogen could be found in the liver twenty-six to thirty-six hours after death, and that a severe infection (pneumonia), chronic disease (tuberculosis) and gastro-intestinal disturbances (diarrhea and vomiting), may be unable to exhaust the glycogen in the liver in certain cases.

June 1.

Syphilis and the Spindle-Shaped Bacillus. H. VINCENT. Syphilitic lesions in the throat invite the fusiform or spindle-shaped bacillus, first described by Vincent. As it colonizes, it modifies the clinical characteristics of the syphilitic lesions and masks their true nature, as if the ulceration were complicated by hospital gangrene. The bacilli are never so numerous, however, as in case of simple angina and they are always associated with other micro-organisms. If the ulceration persists after the bacilli have disappeared under the influence of iodin, to which they are very sensitive, the syphilitic nature is evident. If the lesions become diphtheroid, the false membrane is closely adherent to the subjacent tissue, while the spindle-bacillus false membrane is soft and easily detached. Specific treatment aggravates the true spindle bacillus angina and is thus an important differentiating measure.

June 5.

New and Rapid Method of Differentiating the Typhoid Bacillus in Water. A. CHANTEMESSE.—Eberth's bacillus becomes modified by sojourn in water and this renders its differentiation difficult. In order to obviate this difficulty Chantemesse places the suspected water in a medium that favors proliferation and rejuvenation of the bacillus and proceeds later to its differentiation, after it has regained the characteristics modified by its stay in the water. He describes his method as follows: A Chamberland filtering bougie is placed in a vessel containing six quarts of the suspected water. By producing a vacuum inside the bougie all the microbes in the water are attracted to its outer surface. The bougie is then rinsed with 200 gm. of a 3 per cent. solution of peptone. The turbid fluid thus obtained is kept at 37 C. in a large-mouthed jar with a rubber stopper containing four holes. A small, porous, filtering bougie is inserted in one of the holes; through the second passes a glass tube lightly plugged with cotton, which allows the entrance of air, kept constantly bubbling at the bottom of the jar, as the air is aspirated through a second glass tube in the third hole. The fourth hole holds a glass tube communicating above with a vessel containing the 3 per cent. solution of peptone. The fluid in the jar is changed once or twice every twelve hours by producing a vacuum and then aspirating the fluid out through the filtering bougie, leaving the microbes clinging to its outer surface and the walls of the jar. Fresh culture medium is then introduced through the tube from the receptacle of the solution of peptone above. The culture and the bubbling of the fluid thus commence anew in a fresh, aerated culture medium, with every condition favorable for the cultivation of the microbes. The culture is finally centrifugalized for half an hour and decanted. Most of the slender and extremely motile typhoid bacilli remain in suspension in the fluid and can be transferred directly to the differentiating medium. This is composed of a 3 per cent. solution of peptone, to which 2 per cent. of gelose has been added, and is kept at a temperature of 120 C. for forty-five

minutes. The medium should be absolutely neutral. A few minutes before using, 1.05 gm. of carbolic acid are added to each 1000 gm. of fluid. The medium must be used as a thin pellicle, and about 2 c.c. of the fluid is poured into each one of a dozen tubes in the water-bath at 42 C. They are then sown with a platinum loop taken from the bouillon first poured out of the centrifugalizer, which is ample for four tubes. The platinum loop must therefore be dipped in the bouillon three times to inoculate the dozen tubes. The latter are then warmed to 46 C. in the water-bath and the fluid is spread over the inside of the tube by turning and rolling it. The tube is then placed upside down; the fluid settles to the bottom on the cotton stopper, but a thin pellicle remains adherent to the inner surface of the glass and hardens. The cotton plug is then replaced with a cork taken from a vessel containing melted paraffin. This hermetically seals the tube and prevents the gelose from drying. Kept at 37 C., the colonies of the colon bacillus develop in the course of sixteen to seventeen hours. Each colony visible to the naked eye is marked with ink and the tube is replaced in the oven. By the eighteenth to the twenty-fourth hour a number of new, very small colonies appear, which, as the microscope shows, are formed of the typhoid bacillus and a micrococcus. The bacillus is then transferred to a similar solution of peptone to which lactose has been added. The agglutination test may occasionally differentiate the bacillus at once. The fermentation of the lactose is an important means of differentiating the typhoid bacillus. The fermentation is determined in the neutral fluid with litmus tincture. The medium turns red in the presence of the colon bacillus, while the typhoid bacillus leaves it violet and later turns it blue, or may sometimes decolor the lower portion. This reaction on the part of the lactosed medium—which from neutral at first, becomes gradually alkaline, never acid—and microscopic determination of the characteristics of the typhoid bacillus, establish its identity with positive certainty in three or four days at most. Tests of Seine water from the hydrants always disclosed the typhoid bacilli by this technique and it was found alive in water inoculated with it, after fifteen to forty-four days. Chantemesse concludes by emphasizing the fact that exhaustion, diminished vitality and possibly a peculiar condition of the intestinal flora at certain seasons of the year, may afford the conditions necessary to restore attenuated, non-virulent typhoid bacilli, ingested by man, to pristine virulence, in a manner similar to the influence of the proliferating and rejuvenating conditions in the first stage of his technique.

Revue de Gynecologie (Paris), v, 1 and 2.

Etiology of Extra-Uterine Pregnancy. F. STEPOWSKI.—The conclusions derived from study of thirty-seven cases of extra-uterine pregnancy at Neugebauer's clinic, are that two conditions are indispensable for the production of extra-uterine pregnancy: 1, that the mucous membrane of the tube, under the influence of the fecundated ovum, reacts on the decidua and renders conditions favorable for the incubation of the ovum; 2, the existence of some cause which prevents or paralyzes the passage of the ovum into the matrix.

Permanent Sound for the Ureter. J. ALBARRAN.—After nephrotomy Albarran inserts a sound in the ureter and leaves it for several days, to prevent or cure a renal fistula. It is useful only in urinary or uro-purulent fistulæ—in case of pus alone it can do no good. In this case it is not the kidney, but merely the cellular tissue as such, that is suppurating, and the kidney may be still whole, allowing the urine to be normally voided. When the kidney itself secretes pus, without admixture of urine, the organ is so destroyed that there is no interest in preserving it longer, but in case of simple, purulent fistula the kidney plays but a subordinate role. The organ may still be useful and there is every reason to preserve it. When, however, the kidney has ceased to secrete urine the purulent fistula will heal more rapidly if the useless organ is removed. Catheterization of the ureter is not indicated even in cases of urinary or uro-purulent fistula, if the ureter is impermeable or the bladder irritable. But in appropriate cases he inserts a No. 6 sound in the bladder before the nephrotomy. Then, when the kidney has been exposed and incised, he pushes the tip of this sound into the incision in the kidney, and fits over it a 10 or 11 Charrière sound, with four large eyes in the side and the lower end made to fit over the tip of the No. 6 sound. Both are then drawn down together and worked out through the meatus until the tip of the large sound is in the renal pelvis. The lower end is then fastened with a thread to the skin. The wound in the kidney is then sutured over a drain. The organ is irrigated through the permanent sound two or three times a day. The threads fastening it in place are removed the twelfth day, and it is discarded between the eighteenth and twenty-eighth days. The patients bear the ureteral sound better than the ordinary urethral sound. The result was extremely satisfactory in every one of the fifteen cases described. A fistula developed in eight, but healed over in one to four days. Six were cured, but in one the sounding was a failure, as the ureter was inserted above the bottom of the pelvis. In another, the persistence of gangrenous fragments prevented healing. He left the sound in place for ten to twenty-six days in the cured cases, but has since learned that it is unnecessary to retain it after urine has ceased to trickle through the wound. In two cases symptoms of retention required a repetition of the sounding. When necessary to change the sound, he first inserted a mandrin or guide in it to the tip. He then withdrew the sound over the mandrin and replaced it with another well lubricated sound, which he slipped on over the mandrin to the renal pelvis and then withdrew the mandrin.

Semaine Medicale (Paris), May 29.

Treatment of Old Luxations of the Shoulder. F. LEGUEU.—After failure of the ordinary measures, Legueu cuts an osteo-muscular flap by section of the acromio-clavicular arc, not dividing any of the muscles. Turning this flap over allows wide and easy access to the joint. In a case described in detail the head was found so firmly lodged under the coracoid muscles that it was impossible to dislodge it. In order to do this the coracoid process was cut with the scissors and the muscles attached to it were stretched. This released the head and the hindrance to reposition was found to be a fracture of the anatomic neck of the humerus, with laceration of the capsule and retraction of the capsular opening. The head of the humerus was resected and fitted to the capsule. The coracoid process was sutured with silver wire, the acromion united with the scapula and after insertion of a drain the skin was sutured. The patient could move and bend her arm with ease when dismissed seventeen days later.

Differentiating Sign of Infantile Pneumonia. WEILL.—Pneumonia in young children can be differentiated in its incipiency by the pathognomonic sign described by Weill, the lack of expansion in the subclavicular region, independent of the site of the pneumonic lesion. The little patient being on his back, the chest exposed, and respiration regular, it is easy to note the difference in the expansion between the two sides. On placing the fingers on the subclavicular region on either side, they are lifted as by a wave on the sound side, while on the other the lack of expansion is evident, even in the very first days of the disease. In pleurisy or pneumothorax, the lack of expansion corresponds to the seat of the lesion, but in pneumonia it is invariably subclavicular.

Berliner Klin. Wochenschrift, May 27.

Functional Importance of Pyramidal Tracts. M. ROTHMANN.—Reviewing the clinical and experimental experiences of recent years in regard to the pyramidal tracts, Rothmann concludes that we have no evidence for the assumption that they have any special function. The motor function is the property of the combination of cerebrum, thalamus, corpora quadrigemina and spinal cord. Comparative anatomy, however, shows that the pyramidal tracts are gradually usurping this duty as evolution progresses. They are absent in birds, and in the lower animals are in the posterior columns, and in the lateral columns in the higher animals, while in man they are in both the lateral and anterior columns. This progressive development suggests that the pyramidal tracts are a link in the great chain of phenomena which show that the cerebrum in its evolution is constantly assuming greater predominance

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and subordinating the centers of the mesencephalon and the thalamencephalon.

Chaloderma.—L. Ketly has coined this new term as descriptive of the case of a patient whose skin hangs loose and pendent. The muscles beneath are sound and the skin hangs away from them and bags from the arms, calves and trunk, but the buttocks and mammæ are most conspicuously affected. The changes in the dependent skin are only in the reticular layer and the subcutis. The lack of elastic fibers, and the extreme dilatation of the blood vessels, with a diffuse, small-celled infiltration are noticeable.

Paralysis of the Rectum. A. HESSE.—Wallace has reported a case of alvine incontinence in a child, from paralysis of the rectum, much improved by astringent enemata. Hesse describes a similar case, the patient a boy of 6 with complete paresis of the bladder and anal sphincters, alvine and urinary incontinence, strabismus and chronic intestinal catarrh. He cured the intestinal affection with appropriate diet, tannalbin and Carlsbad waters, and with the subsidence of the catarrhal symptoms, the rectal paralysis was also cured. Partial enuresis still persists, but the lad has been completely relieved of all his other disturbances by this removal of the cause, the chronic catarrh. Hesse urges others to seek the causal factor in some local lesion in these cases, and not be so ready to attribute them to the nervous system.

Deutsche Med. Wochenschrift (Berlin and Leipsic), June 6.

Vicarious Menstruation Through the Bladder. BUENTING.—In a case under the writer's direct observation, menstruation occurred twice through the bronchi, at a year's interval, and ten years later through the bladder. Each time the phenomenon happened in August. The young woman was and is in robust health, with no symptoms on the part of the organs involved.

A Foreign Body as a Hindrance to Delivery. CZARNECKI.—A metal box—10x4 cm. in size—was inserted in the vagina by a girl at her first menstruation for the purpose of checking the flow. She was unable to remove the box later and informed no one of its presence, not even her husband when she married. She passed through an abortion and at that time the box probably slipped into the uterus. The writer was summoned to attend her in childbirth, and delivery was impossible until the box was removed with forceps. The foreign body had thus remained thirteen years in the vagina and eighteen months in the uterus without causing disturbances of any kind until it mechanically interfered with delivery.

Wiener Klin. Wochenschrift, May 23.

Juvenile Form of Progressive Paralysis. J. A. HIRSCHL.—Study of twenty cases of juvenile progressive paralysis showed that congenital lues was a very frequent factor, occurring in 17 out of 20 patients. Also that mentally deficient individuals were more prone to the affection than is the case among adults, and that the prodromal period is characterized by more pronounced symptoms. Another difference is the fact that simple dementia is the usual termination, scarcely ever paralytic mania or paralytic hypochondria, the lack of remissions when the disease is at its height, and that symptoms of irritation as well as seizures are common. The duration is comparatively longer and the autopsy reveals a diffuse sclerosis of the brain with marked leptomeningitis. The affection usually commences between the fourteenth and sixteenth years. Puberty evidently has the same influence as the menopause in paralysis in women, but at the same time it is possible that the paralysis requires the same period for incubation in the young as it does in adults, that is about fifteen years. Assuming that the congenital lues is the causal factor—the same as acquired lues in adults—the period before the outbreak of the paralysis corresponds in each case.

May 30.

Iodoform Filling for Wounds. N. HACKMANN.—Wounds that form a cavity and defects in bones are treated by Mosetig-Moorhof as a dentist fills a tooth. A mixture of oil of sesame, 20 parts; spermaceti, 40, and iodoform, 30 to 60 parts, is melted and poured into the cavity while still warm. It rapidly hardens and fills the cavity completely, bringing the iodoform into close contact with every particle of the tissues. This filling is particularly useful to close cavities in the bones; the tallowy substance is gradually absorbed as new bone is formed. The influence of the materials in the filling is directly stimulating to the tissues, and granulation proceeds more rapidly and satisfactorily than without it. The foreign mass is gradually devoured, as it were, by the crowding granulations. A few cases are described in detail, showing the great benefits derived from this aseptic and antiseptic, stimulating substitute for missing bone or tissues. The filling is sometimes partially expelled by the new tissues forming beneath, in open wounds. The mixture is kept in a bottle inside a thermophor, ready for use. The cavity in the bone may be sterilized with superheated air. In applying the filling to a tuberculous cavity in a long bone, a constricting bandage is applied above, the cavity filled with the mixture and the constricting band removed after it has solidified. The skin is then sutured over the defect. Radiographs taken at intervals show that the filling gradually grows smaller, while the encroaching new formation of bone casts a normal shadow.

St. Petersburger Med. Wochenschrift, May 25.

The Pathology of the Jews. M. KRETZMER.—The exceptional fertility of the Jews and their low mortality are shown in Hoffman's statistics for eighteen years in Prussia. The mortality was 21.61 per cent., while among the rest of the population it was 29.61; the increase during the same period was 34.75 per cent.; in the rest of the population, less than 28 per cent. The excess of boys over girls is another feature of their physiology. Schwimmer found in Austria that 128.5 boys were born to each 100 girls, while the usual proportion is 105.8. The nervous system seems to be the locus minoris resistentiæ among the Jews. The official report for Prussia and Bavaria for the year 1871 showed that there were nearly twice as many Jews among the blind, deaf, dumb and insane as from the remainder of the population. Progressive paralysis and post-puerperal mental disturbances are more frequent; and, in Russia at least, trachoma, myopia, cutaneous affections and abdominal diseases. Affections of the respiratory passages are less frequent among the Jews. Recent military statistics showed that consumptives in the army were in the proportion of 1 Jew to 22.3 Christians and 1.7 Mohammedans. Eminent Jews in the profession of late years are Traube, Heidenhain, Henle, Cohnheim, Bernstein, Senator, Liebreich, Saenger, Freund, Jaffe, Schreiber, Mendel, Hirschberg, Zuckerkandl and Meynert.

New Patents.

Patents of interest to physicians, etc., June 4 and 11:

675,556. Atomizer. Alfred Clarkson, Fall River, Mass.
675,821. Attachment for truss pads. Cornelius Donovan, New York City.
675,775. Apparatus for filling capsules. John G. Gilmer, St. Petersburg, Fla.
675,739. Device for testing eyes. Christian F. Kantlehner, Chelsea, Mich.
675,674. Elevating or lowering device for dental chairs. Frank Ritter, Rochester, N. Y.
675,678. Movement cure apparatus. Charles A. Scholder, Lausanne, Switzerland.
675,700. Device attached to hats to aid in hearing. Albert G. Zimmerman, Chicago.
676,178. Mercurial barometer. Arthur S. Davis, Leeds, England.
676,124. Hot-air cabinet. Henry A. Dygert, Philadelphia.
675,897. Water-bag syringe. Wm. D. Martin, Warsaw, N. Y.
675,966. Inhaler. John Y. McFarland, Chicago.
676,269. Return-flow syringe. Denwood N. L. Newbury, New York City.
676,158. Shirt for invalids. Wm. E. St. John, Leonardsville, N. Y.
676,283. Tonsillotome. Ernst Stratmann, New York City.
676,379. Eye-cups. Frank E. Young, Canton, Ohio.

The Public Service.

Army Changes.

Movements of Army Medical Officers under orders from the Adjutant-General's Office, Washington, D. C., June 6 to 12, 1901, inclusive:

Percy M. Ashburn, lieutenant and asst.-surgeon, U. S. A., on his arrival at San Francisco, Cal., will proceed to Fort Sheridan, Ill., for post duty.

Thomas S. Bratton, captain and asst.-surgeon, U. S. A., from duty in the Division of the Philippines, to Fort Clark, Texas.

William J. Calvert, lieutenant and asst.-surgeon, U. S. A., on

his arrival at San Francisco, Cal., to proceed to Washington Barracks, D. C., for duty at the General Hospital at that place.

W. Fitzhugh Carter, major and surgeon, U. S. A., leave of absence granted.

Henry R. Carter, Jr., contract surgeon, from Vancouver Barracks, Wash., to San Francisco, Cal., en route for duty in the Division of the Philippines.

Edward T. Comegys, major and surgeon, U. S. A., relieved from further duty in the Division of the Philippines; on the expiration of his present sick leave he will report for duty at Fort Meade, S. D.

William D. Crosby, major and surgeon, U. S. A., from New York City, to post duty at Fort McPherson, Ga.

J. Ryan Devereux, contract surgeon, from Washington Barracks, D. C., to temporary duty at Fort McPherson, Ga.

Basil H. Dutcher, lieutenant and asst.-surgeon, U. S. A., now on duty in the U. S. Military Hospital, Nagasaki, Japan, is relieved from duty in the Division of the Philippines, and will proceed to Fort Hancock, N. J., for post duty.

James J. Erwin, captain and asst.-surgeon, Vols., honorably discharged from the service of the United States, to take effect June 30, 1901.

Powell C. Fauntleroy, major and surgeon, Vols. (captain and asst.-surgeon, U. S. A.), relieved from further duty in the Division of the Philippines and will proceed to Madison Barracks, N. Y., for post duty.

Joseph H. Ford, lieutenant and asst.-surgeon, U. S. A., from the Division of the Philippines to Fort Washington, Md., for post duty.

Clyde S. Ford, lieutenant and asst.-surgeon, U. S. A., from the Division of the Philippines to duty at Fort Morgan, Ala.

Harry L. Gilchrist, lieutenant and asst.-surgeon, U. S. A., on his arrival at San Francisco, Cal., will proceed to Vancouver Barracks, Wash., for duty at that post.

Charles R. Gill, contract surgeon, former orders revoked; he will proceed to Fort Totten, N. Y., to accompany the Second Battalion of Engineers from that post to San Francisco, Cal.

Joseph R. Girard, lieutenant-col., deputy surgeon-general, U. S. A., from duty at the Medical Supply Depot, St. Louis, Mo., to Vancouver Barracks, Wash., as post surgeon and chief surgeon, Department of the Columbia.

Henry S. Greenleaf, lieutenant and asst.-surgeon, U. S. A., from the Division of the Philippines to duty at Abeatraz Island, Cal.

Richard S. Griswold, major and surgeon, Vols., recently appointed and now in New York City, N. Y., to proceed to San Francisco, Cal., en route for service in the Division of the Philippines.

Harry M. Hallock, captain and asst.-surgeon, U. S. A., from Fort McPherson, Ga., to San Francisco, Cal., en route for service in the Division of the Philippines.

Eugene H. Hartnett, Lieutenant and asst.-surgeon, U. S. A., on his arrival at San Francisco, Cal., will proceed to Fort Columbus, N. Y., for duty at that post.

Deane C. Howard, captain and asst.-surgeon, U. S. A., former orders amended so as to direct him to proceed to Havana, Cuba, for duty in the Department of Cuba.

John S. Kulp, major and surgeon, Vols., so much of former orders as assigns him to Fort Hancock, N. J., is amended, assigning him to duty in New York City, as attending surgeon, examiner of recruits, and medical superintendent of the Army Transport Service.

Walter D. McCaw, major and surgeon, U. S. Army, detailed a member of the board in session at Manila, P. I., for the examination of candidates for admission to the Medical Corps of the Army, relieving Major William J. Wakeman, surgeon, U. S. Army.

H. E. Menage, contract surgeon, leave of absence from the Department of the Colorado extended.

Ben H. Metcalf, contract surgeon, to report from Fort Banks, Mass., by letter to the Surgeon-General for annulment of contract.

Edward W. Pinkham, lieutenant and asst.-surgeon, U. S. A., on arrival at San Francisco, Cal., will report for duty at Fort Banks, Mass.

Walter Reed, major and surgeon, U. S. A., from Washington, D. C., to Fort Monroe, Va., on official business, on the completion of which he will return to his proper station.

Edward R. Schreiner, lieutenant and asst.surgeon, U. S. A., from duty in the Division of the Philippines, to Fort Howard, Md.

Samuel L. Steer, lieutenant and asst.-surgeon, U. S. A., on arrival at San Francisco, Cal., will proceed to Fort Dupont, Del., for duty at that place.

Henry R. Stiles, captain and asst.-surgeon, U. S. A., from Madison Barracks, N. Y., to San Francisco, Cal., en route for service in the Division of the Philippines.

Samuel M. Waterhouse, lieutenant and asst.-surgeon, U. S. A., from Fort Meade, S. D., to San Francisco, Cal., en route for service in the Division of the Philippines.

Roy A. Wilson, contract surgeon, from Fort Totten, N. Y., to San Francisco, Cal., en route for service in the Division of the Philippines.

Francis A. Winter, captain and asst.-surgeon, U. S. Army, from Fort Sheridan, Ill., to duty at Jefferson Barracks, Mo.

Halsey L. Wood, contract surgeon, leave of absence granted.

Marshall W. Wood, major and surgeon, U. S. A., from Jefferson Barracks, Mo., to St. Louis, Mo., to take charge of the Medical supply depot in that city.

Navy Changes.

Changes in the Medical Corps of the Navy, week ended June 15, 1901:

Dr. G. M. Mayers, appointed asst.-surgeon, from June 1, 1891.

Asst.-Surgeon J. F. Murphy, ordered to the Naval Academy, June 15.

Surgeon A. R. Wentworth, detached from the *Solace* and ordered to the *Albany*.

Surgeon H. N. T. Harris, detached from the *Albany* and ordered to the *Monocacy*.

P. A. Surgeon S. G. Evans, detached from the *Monocacy* and ordered to the *Solace*.

Asst.-Surgeon J. W. Backus, ordered to the *Vermont*, June 17.

Asst.-Surgeon F. A. Asserson, ordered to the Naval Hospital, New York, June 17.

Asst.-Surgeon G. M. Mayers, ordered to the Pensacola Navy Yard, June 18.

Marine-Hospital Changes.

Official list of the changes of station and duties of commissioned and non-commissioned officers of the U. S. Marine-Hospital Service, for the fourteen days ended June 13, 1901:

Surgeon J. H. White, to report at Washington, D. C., for conference.

Surgeon L. L. Williams, granted leave of absence for five days from June 6.

Surgeon W. J. Pettus, granted leave of absence for three days from June 13.

P. A. Surgeon J. A. Nydegger, granted leave of absence for thirty days from June 8.

P. A. Surgeon E. K. Sprague, granted leave of absence for thirty days from May 30.

P. A. Surgeon H. W. Wickes, granted leave of absence for four days from June 3.

Asst.-Surgeon C. E. Decker, granted leave of absence for ten days, on account of sickness.

Asst.-Surgeon W. W. King, granted leave of absence for four days.

A. A. Surgeon J. E. Bready, granted leave of absence for one day, June 19.

A. A. Surgeon Henry Ecroyd, granted leave of absence for ten days from June 8.

A. A. Surgeon W. C. Mason, granted leave of absence for six days from June 23.

A. A. Surgeon F. R. Smyth, leave of absence for three days granted by bureau telegram of May 31, 1901, revoked.

A. A. Surgeon J. G. Stanton, granted leave of absence for fifteen days from June 3.

BOARD CONVENED.

Board convened to meet at Washington, D. C., on June 7, 1901, for the physical examination of an applicant for cadetship in the U. S. Revenue-Cutter Service. Details for the Board: P. A. Surgeon H. D. Geddings, chairman; Asst.-Surgeon B. S. Warren, recorder.

Health Reports.

The following cases of smallpox, yellow fever, cholera and plague have been reported to the Surgeon-General, U. S. Marine-Hospital Service, during the week ended June 15, 1901:

SMALLPOX—UNITED STATES AND INSULAR.

Alaska: Douglas City, May 25, 5 cases.

California: San Francisco, May 25-June 1, 4 cases.

District of Columbia: Washington, May 30, 1 case.

Illinois: Chicago, June 1-9, 6 cases.

Indiana: Michigan City, June 3-10, 2 cases; South Bend, June 1-8, 1 case.

Kansas: Wichita, June 1-8, 7 cases, 1 death.

Louisiana: New Orleans, June 1-9, 5 cases, 1 death; Shreveport, May 25-June 1, 2 cases.

Maine: Portland, June 1-8, 1 case.

Maryland: Baltimore, June 1-8, 1 case.

Massachusetts: Boston, June 1-8, 1 case; Fall River, June 1-8, 1 case; Marlboro, June 1-5, 1 case; New Bedford, June 1-8, 27 cases, 1 death; Somerville, June 1-8, 1 case.

Michigan: June 1-8, Detroit, 33 cases; West Bay City, 1 case.

Minnesota: Winona, June 1-8, 1 case; St. Louis, May 26-June 2, 32 cases.

New Hampshire: Manchester, June 1-8, 4 cases.

New York: New York, June 1-8, 86 cases, 16 deaths.

Ohio: Cincinnati, May 31-June 7, 5 cases; Cleveland, June 1-8, 30 cases; Toledo, June 1-8, 1 case.

Pennsylvania: June 1-8, Lebanon, 1 case; Philadelphia, 1 death; Pittsburg, 5 cases.

Rhode Island: Providence, June 1-8, 1 case, 1 death.

Utah: Ogden, May 1-31, 11 cases; Salt Lake City, June 1-8, 4 cases.

Washington: Tacoma, May 26-June 2, 1 case.

Wisconsin: Green Bay, June 2-9, 2 cases.

Philippines: Manila, April 13-20, 9 cases.

Porto Rico: San Juan, May 10, extinct, 8 cases on island.

SMALLPOX—FOREIGN.

Austria: Prague, May 18-25, 3 cases.

Belgium: Antwerp, May 18-25, 3 cases, 1 death.

Brazil: Pernambuco, April 1-15, 27 cases.

China: Hongkong, April 22-27, 7 cases, 5 deaths.

Colombia: Panama, May 27-June 3, 5 cases, 1 death.

France: Paris, May 18-25, 15 deaths.

Great Britain: Glasgow, May 25-31, 42 cases, 1 death.

Greece: Athens, May 18-25, 2 cases.

India: Calcutta, May 4-11, 34 deaths; Karachi, April 28-May 12, 9 cases, 3 deaths.

Italy: Naples, May 19-26, 161 cases, 28 deaths.

Japan: Nagasaki, May 6, 1 case on U. S. S. *Indiana*; Tokyo, May 11, 3 cases.

Manitoba: Winnipeg, May 25, June 1, 2 cases.

Mexico: Mexico City, May 19-June 2, 3 deaths.

Russia: Odessa, May 11-26, 9 cases, 1 death; St. Petersburg, May 4-18, 24 cases, 5 deaths; Warsaw, May 4-11, 8 deaths.

YELLOW FEVER.

Mexico: Vera Cruz, May 18-25, 1 death.

CHOLERA.

India: Bombay, May 7-14, 3 deaths; Calcutta, May 4-11, 47 deaths.

PLAGUE—FOREIGN AND INSULAR.

Africa: Cape Town, to April 5, 412 cases, 181 deaths.

China: Hongkong, April 20-27, 65 cases, 55 deaths.

India: Bombay, May 7-14, 289 deaths; Calcutta, May 4-11, 134 deaths; Karachi, April 28-May 12, 657 cases, 563 deaths.

Japan: Formosa, May 19, increasing; from May 3-June 1, 2157 cases.

Philippines: Manila, April 13-20, 27 cases, 16 deaths.

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